State of Wisconsin
DOA-3261 (R08/2003)
s.16.75, Wis. Statutes

PROPOSALS MUST BE SEALED AND ADDRESSED TO:

AGENCY ADDRESS:

Department of Health Services
Long-term Care Infrastructure Project; Third Party Administration
Patricia McCollum, Procurement Manager
1 W. Wilson, Room 750
PO Box 7850
Madison, WI 53707-7850

REQUEST FOR PROPOSAL

THIS IS NOT AN ORDER

PROPOSER (Name and Address)

☐ Remove from proposer list for this commodity/service. (Return this page only.)

Proposal envelope must be sealed and plainly marked in lower corner with due date and Request for Proposal # **1677-DLTC-PM**. Late proposals will be rejected. Proposals MUST be date and time stamped by the soliciting purchasing office on or before the date and time that the proposal is due. Proposals dated and time stamped in another office will be rejected. Receipt of a proposal by the mail system does not constitute receipt of a proposal by the purchasing office. Any proposal which is inadvertently opened as a result of not being properly and clearly marked is subject to rejection. Proposals must be submitted separately, i.e., not included with sample packages or other proposals. Proposal openings are public unless otherwise specified. Records will be available for public inspection after issuance of the notice of intent to award or the award of the contract. Proposer should contact person named below for an appointment to view the proposal record. Proposals shall be firm for acceptance for sixty (60) days from date of proposal opening, unless otherwise noted. The attached terms and conditions apply to any subsequent award.

Proposals MUST be in this office no later than	Public Opening ☐
1:00 p.m. CT on 07/29/2009	No Public Opening ☒

Name (Contact for further information)

Patricia McCollum

Phone	Date
(608) 266-2628	05/07/2009

Quote Price and Delivery FOB

Description

Third Party Administration Claims Processing Services for Medicaid Home and Community-Based Waivers

Payment Terms:	Delivery Time:

☐ We claim minority bidder preference [Wis. Stats. s. 16.75(3m)]. Under Wisconsin Statutes, a 5% preference may be granted to CERTIFIED Minority Business Enterprises. Bidder must be certified by the Wisconsin Department of Commerce. If you have questions concerning the certification process, contact the Wisconsin Department of Commerce, 5th Floor, 201 W. Washington Ave., Madison, Wisconsin 53702, (608) 267-9550.

☐ We are a work center certified under Wis. Stats. s. 16.752 employing persons with severe disabilities. Questions concerning the certification process should be addressed to the Work Center Program, State Bureau of Procurement, 6th Floor, 101 E. Wilson St., Madison, Wisconsin 53702, (608) 266-2605.

Wis. Stats. s. 16.754 directs the state to purchase materials which are manufactured to the greatest extent in the United States when all other factors are substantially equal. Materials covered in our bid were manufactured in whole or in substantial part within the United States, or the majority of the component parts thereof were manufactured in whole or in substantial part in the United States.

☐ Yes ☐ No ☐ Unknown

In signing this proposal we also certify that we have not, either directly or indirectly, entered into any agreement or participated in any collusion or otherwise taken any action in restraint of free competition; that no attempt has been made to induce any other person or firm to submit or not to submit a proposal; that this proposal has been independently arrived at without collusion with any other proposer, competitor or potential competitor; that this proposal has not been knowingly disclosed prior to the opening of proposals to any other proposer or competitor; that the above statement is accurate under penalty of perjury.

We will comply with all terms, conditions and specifications required by the state in this Request for Proposal and all terms of our proposal.

Name of Authorized Company Representative (Type or Print)	Title	Phone ( )
		Fax ( )

Signature of Above	Date	Federal Employer Identification No.	Social Security No. if Sole Proprietor (Voluntary)

This form can be made available in accessible formats upon request to qualified individuals with disabilities.

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1.0 GENERAL INFORMATION

1.1 Introduction and background

The purpose of this document is to provide interested parties with information to enable them to prepare and submit a proposal to provide Third Party Administration claims processing services, managed care encounter service reporting, and other claims processing related services for Long-term Care Managed Care Organizations (MCOs) and other agencies delivering Department programs. The State as represented by the Department of Health Services Division of Long Term Care intends to use this solicitation to award a contract for two purposes:

- To provide DHS with a vehicle to procure Third Party Administrator (TPA) services to provide claims processing and related business services for selected programs administered by the state.
- To establish a contract that may be used by the Department's program delivery agencies (e.g., Managed Care Organizations and county waiver agencies) to obtain Third Party Administrator (TPA) services to provide claims processing and related services.

This Request for Proposal (RFP) is issued by the State of Wisconsin Department of Health Services (DHS) to establish a Third Party Administration contract that meets the informational, operational, and administrative needs necessary to support the day-to-day claims management of the Wisconsin Long Term Care Managed Care and other programs.

DHS currently intends to enter into a master agreement with the TPA that will establish a core set of service requirements, contract terms and conditions, and pricing structure that will ensure uniformity among the Department's program delivery agencies. The TPA and program delivery agency will then contract, adding any optional services included in this RFP (such as ancillary support services for consulting and technical assistance), at the rates proposed in the TPA’s response.

1.2 Scope of the project

Project description

The Department is seeking to contract for the services of a TPA to perform claims processing, encounter reporting, and other claims processing related services for its Medicaid Home and Community-Based Waiver programs, and other long-term support programs as designated by the Department.

The Family Care Business Infrastructure and Systems Project, conducted by an independent consultant under the direction of the Secretary of the Department of Health Services in 2008, advised that greater program efficiency and effectiveness can be obtained through expanded collaboration between program delivery agencies and the Department. This approach offers significant advantages for both the state's stewardship responsibilities and the service delivery responsibilities of program agencies:

- State-wide program consistency; uniformity in member experiences.

- Higher efficiency; opportunities to reduce administrative costs.
- Improved member outcomes; opportunities to develop and share better-best practices.
- Standardization and technical support; standardized processes to facilitate technical support opportunities across organizations.
- Reduced risk; the DHS becomes more proactive in ensuring the performance needs of program delivery agencies are met.

Overall, the Department is seeking administrative cost savings and uniformity in program delivery by taking advantage of opportunities to use consolidated outsourced and shared services, consistent with a more proactive collaborative approach, through:

- Use of common information technology systems to reduce costs and promote standard practices.
- Use of cooperative purchasing to take advantage of procuring in greater volume.
- Outsourcing of some MCO business functions to promote focusing on core program responsibilities and take advantage of specialized expertise to perform other operations.

The Department's action items in this area are to first pursue establishing a single source for claims processing services through this RFP, and then explore broader system packaging opportunities in the market place and leveraging existing Department systems that could benefit MCO operations support. These initiatives are seen as touching all of the above points; using common information systems, seeking volume discounting, and outsourcing to take advantage of specialized expertise.

Objectives

The Department’s goal is to support the effective and efficient management of business operations and service delivery of the existing Family Care and Family Care Partnership organizations, while ensuring that organizations participating in the expansion of Family Care build the necessary business infrastructure and business systems to support program requirements. This goal also extends to business operations and service delivery of other DHS Medicaid Home and Community-Based Waiver programs.

Singular acquisition of claims processing services has been selected as one of the most frequently outsourced business functions critical to the operations of all MCOs and other organizations, and essential in providing crucial information for both the program delivery agencies and the state's rate setting and performance oversight responsibilities.

The Department anticipates that MCOs and other organizations statewide will transition to this TPA services procurement over a period of time; however, there may be several concurrent transitions in any given time period. The rate of transition will be determined by the Department and is dependent on funding and legislative initiatives, but is currently expected to occur throughout the next biennium.

This RFP focuses on infrastructure and business systems for claims management. The Department may issue subsequent requests for information related to a broader array of

business systems and operations required to support MCOs and other program delivery agencies, including counties.

Current programs

Current service delivery programs include the Family Care program, the Family Care Partnership program, the Program of All-inclusive Care for the Elderly (PACE), and the Children's Long-Term Support (CLTS) Medicaid waiver programs.

These Medicaid Home and Community-Based Waiver programs, and other long-term support programs are comprehensive, flexible long-term care service systems that strive to foster independence and quality of life, while recognizing the need for health, safety and support services. The scope of these programs includes both medical and non-medical, community based services; any systems used to administer these programs must support atypical service providers.

Claims processing functions are currently met in a wide variety of ways; some organizations contract with a vendor or multiple vendors to process claims, while others handle claims functions internally using a variety of manual and automated processes.

Enrollment totals for Family Care, Family Care Partnership, and PACE are expected to reach 53,000 members. Enrollment for CLTS programs is expected to reach approximately 5,000 participants.

Individual program enrollment totals and organizations providing benefits of the Family Care, Family Care Partnership, PACE, and CLTS programs are listed below. This list of organizations is current as of the date of issue of this RFP; however, the list only reflects this point in time. Changes are occurring rapidly as the program expansion efforts progress and more organizations are formed and begin operation.

Family Care Program

Family Care is a comprehensive and flexible long-term care service system, which strives to foster people's independence and quality of life, while recognizing the need for interdependence and support. The goals of Family Care are to:

- Give people better choices about the services and supports available to meet their needs.
- Improve people's access to services.
- Improve the overall quality of the long-term care system by focusing on achieving people's health and social outcomes.
- Create a cost-effective long-term care system for the future.

The Family Care benefit package includes medical and non-medical services as defined in Wisconsin’s CMS (Centers for Medicare & Medicaid Services) approved s. 1915 (c) home and community-based waiver services waivers, as well as State Plan services. Services defined under Wisconsin statutes and administrative code may be further clarified in Wisconsin Medicaid Program Provider Handbooks and Bulletins, MCO Contract Interpretation Bulletins and as otherwise specified in contracts between DHS and MCOs. Family Care benefits include, but are not limited to:

Adaptive aids.
Adult day care services.
AODA day treatment services.
AODA services (not inpatient or physician provided).
Care/case management services.
Communication aids.
Community support program.
Consumer-directed supports (self-directed supports).
Consumer education and training.
Counseling and therapeutic resources.
Durable medical equipment (except hearing aids and prosthetics).
Financial management services.
Habilitation, including:
- Daily living skills training.
- Day center service/treatment.
- Day services for children.
- Prevocational services.
- Supported employment services.
- Vocational futures planning (VFP).

Home delivered meals.
Home health.
Home modifications.
Housing counseling.
Medical supplies.
Mental health day treatment services.
Mental health services (not inpatient or physician provided).
Nursing facility including ICF/MR and IMD.
Nursing services (including respiratory care, intermittent and private duty nursing).
Occupational therapy (except inpatient hospital).
Personal care.
Personal emergency response system (PERS).
Physical therapy (except inpatient hospital).
Relocation services.
Residential care, including:
- Adult family homes for 1-2 beds.
- Adult family homes for 3-4 beds.
- Children's foster homes/treatment foster homes.
- Community-based residential facilities (CBRF).
- Residential care apartment complexes (RCAC).

Respite care services.
Skilled nursing services.
Specialized medical equipment and supplies.
Specialized transportation services.
Speech/language pathology (except inpatient hospital).
Supportive home care (SHC) services.
Transportation services (except ambulance and common carrier).

Total enrollment for the Family Care program as of 4/1/2009 is 21,668 people.
Organizations providing the Family Care program:

- Southwest Family Care Alliance

- Western Wisconsin Cares
- Care Wisconsin First, Inc.
- Community Care of Central Wisconsin
- CHP-LTS, Inc.
- Community Care, Inc.
- Creative Care Options
- Milwaukee County Department on Aging
- Northern Bridges

Family Care Partnership Program and PACE

The Family Care Partnership Program is a comprehensive waiver program that integrates health and long-term support services for people who are elderly or disabled. The goals of Partnership are to:

- Improve quality of health care and service delivery while containing costs.
- Reduce fragmentation and inefficiency in the existing health care delivery system.
- Increase the ability of people to live in the community and participate in decisions regarding their own health care.

The Family Care Partnership Program integrates Medicare, Medicaid, and home and community-based waiver services into a single health plan with coordinated coverage for a range of services from clinic visits and home health care to hospital and nursing home stays. Partnership covered services include, but are not limited to:

Adult day care.
Complementary therapies.
Counseling.
CBRF.
Home health services.
Home modification and home repair.
Hospital.
Meals.
Medical specialty care.
Nursing home.
Occupational therapy.
Over the counter medications.
Personal care services.
Pharmacy.
Physical therapy.
Primary medical care.
Speech therapy.
Transportation.

Total enrollment for the Family Care Partnership program as of 4/1/2009 is 3,245 people. Organizations providing the Family Care Partnership program:

- Care Wisconsin Health Plan, Inc.
- Partnership Health Plan, Inc.
- Community Care Health Plan, Inc.

The Program of All-inclusive Care for the Elderly (PACE) also provides comprehensive community based services, including both acute and chronic care, to frail elderly individuals. Covered benefits are the same as those for Family Care Partnership.

Total enrollment for PACE as of 4/1/2009 is 878 people. The organization providing PACE is:

- Community Care, Inc.

Detailed information regarding the Family Care and Family Care Partnership programs can be found on the DHS web site at http://dhs.wisconsin.gov/ltcare/INDEX.HTM.

Children's Long-Term Support (CLTS) Waivers

The Children's Long-Term Support (CLTS) Waivers were submitted to the federal CMS for review under the Medicaid rules that permit states to flexibly use Medicaid funds for community supports and services. These home and community-based service (HCBS) waiver programs give the state the flexibility to develop and implement creative alternatives to placing Medicaid-eligible individuals in hospitals, nursing facilities or intermediate care facilities for persons with mental retardation. The HCBS waiver program recognizes that many individuals at risk of being placed in these facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

The CLTS Waivers are Medicaid 1915(c) home and community-based services waivers approved by the Centers for Medicare and Medicaid in 2003 and in operation since 2004 in Wisconsin. There are three waivers that operate for the following federally defined target groups: developmental disabilities (DD), physical disabilities and severe emotional disturbance (SED).

The waivers offer a broad array of community supports, and the DD and SED waivers also include intensive in-home autism treatment services for children with Autism Spectrum Disorders. Currently, the services that a child receives are reported to the Human Services Reporting System (HSRS) and then payments for services are made via the Community Aides Reporting System (CARS). Direct payments are made to the service providers typically on a monthly or biweekly basis. Services and claiming may not duplicate Medicaid Card Services available under the Medicaid State plan and the waivers are a payer of last resort. Also, many children also have private insurance coverage through their families' policies and these sources must also pay in advance of all public payers.

The CLTS Waivers and other home and community-based services waivers are primarily operated by county human services, social services and community programs. These programs operate in all 72 counties in Wisconsin. There are also several non-profit organizations that manage and operate services in multiple locations throughout the state, and two additional contracts with St. Francis Children's Center and Lutheran Social Services to manage autism treatment services.

Currently, Individual Service Plan (ISP) authorization occurs at the local level with state oversight as appropriate to the approved waivers with the Centers for Medicare and

Medicaid Services (CMS). Once authorized, the provider of the specific service is issued a contract through the county on behalf of the State Medicaid Agency (DHS). This is a fee-for-service process meaning that after the planned and authorized service is delivered to an eligible individual, then the service provider submits a claim for payment to the county. CMS has also directed DHS that should a service provider prefer to contract and invoice the state agency directly, the DHS must then fulfill this role.

This is a family-centered system of services and supports to assure that children remain in the community rather than more restrictive institutional settings. Services include:

Adaptive Aids
Adult Day Care
Adult Family Home (1-4 beds)
Communication Aids
Consumer Education and Training
Counseling and Therapeutic Resources
Daily Living Skills Training
Day Services
Home Modification
Housing Counseling and Housing Start - Up
Intensive In-Home Autism Treatment Services
Personal Emergency Response System
Respite
Self-Directed/Family-Directed Supports
Specialized Medical Equipment and Supplies
Supportive Home Care
Transportation

As of 3/31/09, 3,756 children are receiving services through the CLTS Waivers. This includes 2,034 children who have received or are currently receiving (743) intensive in-home autism treatment services. The number of children projected to be added to the CLTS waivers over the next four years is approximately 1,000. Additionally, approximately 150 children with autism will be added per year. Children are served by county agencies in all 72 Wisconsin counties, as well as Lutheran Social Services and St. Francis Children's Center.

Information on the Wisconsin Legislative statutes regarding these programs can be found at http://www.legis.state.wi.us/statutes/Stat0046.pdf.

1.3 Procuring and contracting agency

This RFP is issued by the Wisconsin Department of Health Services, which is the sole point of contact for the State of Wisconsin during the selection process. The person responsible for managing the procurement process is Patricia McCollum; (608) 266-2628 (voice) or Patricia.McCollum@wisconsin.gov (e-mail).

The goal of this RFP is to select the vendor(s) that will be available to program delivery agencies, including Family Care, Family Care Partnership and Children's Long Term Support Waiver organizations, for claims processing and related services. The vendor(s) will enter into a DHS-supplied master agreement, but DHS will not manage the contractual

relationship the TPA has with the individual organizations. The program delivery agencies will enter into an addendum with the TPA detailing the scope of services that is tailored to meet each agency's needs. Program organizations will directly pay the selected vendor(s) for the claims processing and additional services based upon the pricing established through the procurement, using terms specified in their individual contracts.

DHS will have the discretion to purchase special vendor supports, for example training, if that is more cost-effective than having each program organization contract for this type of ancillary support.

1.4 Definitions

The following definitions are used throughout the RFP.

Agency means the Wisconsin Department of Health Services.

Atypical provider means a provider of non-medical or non-health related services, which may be included in community based service programs.

Bulletin (or bulletin level) means negotiated and agreed upon with the Department.

Business operations are those ongoing recurring activities involved in the running of a business for the purpose of producing value for the stakeholders.

Clean claim is a claim that can be processed without obtaining additional information from the service provider or a third party; it does not include a claim from a provider under investigation for fraud or abuse, or a claim under review for medical necessity. A clean claim includes relevant details and documentation adequate to determine whether the claim is payable under the program's benefit plan.

Contractor means the vendor awarded the contract.

Contracting organization means the MCO or other agency contracting with the selected vendor(s).

County waiver agency means an entity that administers children's long-term support programs.

Enrollee means a person enrolled in a Long-term Care Managed Care program.

Medicaid means Wisconsin Medicaid.

Member means a person enrolled in a Long-term Care Managed Care program.

Member share means payments received from a person enrolled in a Long-term Care Managed Care program, to be applied to their obligation for cost share, room and board, spend down, or other voluntary contributions made toward the cost of their care.

Participant means a person enrolled in a Long-term Care Managed Care program, particularly a recipient of children's waiver services.

Proposer / vendor means a firm submitting a proposal in response to this RFP.

Recipient means a person enrolled in a Long-term Care Managed Care or other waiver program.

State means State of Wisconsin.

Waiver / waiver programs means the federal government has issued a waiver of Medicaid policy for the purposes of program administration in specified areas.

The following abbreviations are used throughout this RFP.

ADA	Americans with Disabilities Act
AMA	American Medical Association
AWP	Average Wholesale Price
CARS	Community Aides Reporting System
CDT	Current Dental Terminology
CLTS	Children's Long-Term Support
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
COB	Coordination of Benefits
CLTS	Children's Long-Term Support
DD	Developmental Disabilities / Developmentally Disabled
DHS	Department of Health Services
DME	Durable Medical Equipment
DRG	Diagnostic Related Group
DUR	Drug Utilization Review
EAC	Estimated Acquisition Cost
EFT	Electronic Funds Transfer
eHR	electronic Health Record
EOB	Explanation of Benefits
FFS	Fee for Service
GAAP	Generally Accepted Accounting Principles
GCN	Generic Code Number
HCBW	Home and Community-Based Waiver
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HSRS	Human Services Reporting System
IBNR	Incurred But Not Reported
ICN	Internal Control Number
ISP	Individual Service Plan
LTC	Long-Term Care

MAC	Maximum Allowable Cost
MCO	Managed Care Organization
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
OFCE	Office of Family Care Expansion
PACE	Program of All-inclusive Care for the Elderly
PBM	Pharmacy Benefit Manager/management
PMPM	Per Member Per Month
POS	Point of Sale
QA/QI	Quality Assurance / Quality Improvement
RFP	Request for Proposal
SED	Severe Emotional Disturbance
SPC	Standard Program Category
SSN	Social Security Number
TPA	Third Party Administrator/Administration
TPL	Third Party Liability

1.5 Clarification and/or revisions to the specifications and requirements

Any questions concerning this RFP must be submitted in writing **on or before 4:00 p.m. CT on 06/16/2009** to:

Patricia McCollum, Procurement Manager
Department of Health Services
1 W. Wilson, Room 750
PO Box 7850
Madison, WI 53707-7850
Phone: (608) 266-2628
FAX: 608-264-9874
E-Mail: Patricia.McCollum@wisconsin.gov

Vendors are expected to raise any questions, exceptions, or additions they have concerning this RFP at this point in the RFP process. If a vendor discovers any significant ambiguity, error, conflict, discrepancy, omission, or other deficiency in this RFP, the vendor should notify immediately the above named individual of such error and request modification or clarification of the RFP.

Written questions that are received prior to the date and time noted above will be published on VendorNet with the Department's response. In the event that it becomes necessary to provide additional clarifying data or information, or to revise any part of this RFP, revisions/amendments and/or supplements will be published on VendorNet.

Prospective proposers are requested to submit a Letter of Intent stating their plan to submit a proposal in response to this RFP to the Department of Health Services **on or before 4:00 p.m. CT on 06/26/2009.** The Letter of Intent should be delivered, faxed, or sent by certified mail to the procurement manager listed above.

Each proposal shall stipulate that it is predicated upon the requirements, terms, and conditions of this RFP and any supplements or revisions thereof.

Any contact with State employees concerning this RFP is prohibited, except as authorized by the procurement manager during the period from date of release of the RFP until the notice of intent to contract is released.

1.6 Reasonable accommodations

The Department will provide reasonable accommodations, including the provision of informational material in an alternative format, for qualified individuals with disabilities upon request. If you think you need accommodations, contact Patricia McCollum at (608) 266-2628 (voice) or Patricia.McCollum@wisconsin.gov (e-mail).

1.7 Calendar of events

Listed below are specific and estimated dates and times of actions related to this Request for Proposal (RFP). The actions with specific dates must be completed as indicated unless otherwise changed by the State. In the event that the State finds it necessary to change any of the specific dates and times in the calendar of events listed below, it will do so by issuing a supplement to this RFP. There may or may not be a formal notification issued for changes in the estimated dates and times.

DATE	EVENT
06/02/2009	Date of issue of the RFP.
06/16/2009	Last day for submitting written inquires by 4:00 p.m. CT.
06/22/2009*	State publishes responses to questions, supplements, or revisions to RFP on VendorNet.
06/26/2009	Last day for submitting intent to propose by 4:00 p.m. CT.
07/29/2009	Proposals due from vendors by 1:00 p.m. CT.
08/20/2009*	Demos by invited vendors or on-site visits by evaluation committee, as needed.
09/18/2009*	Notification of intent to award sent to vendors.
10/01/2009*	Contract begins.

(* Approximate date.)

1.8 Contract term

Any contract with the State resulting from this RFP shall be effective on the date indicated on the purchase order or the contract execution date and shall run for five years from that date, with an option by mutual agreement of the agency and contractor, to renew for two additional two-year periods.

Contract terms in addition to the master agreement shall be negotiated between the MCO/county waiver agency and the selected vendor(s).

1.9 VendorNet registration

The State of Wisconsin's purchasing information and vendor notification service is available to all businesses and organizations that want to sell to the state. Anyone may access VendorNet on the Internet at http://vendornet.state.wi.us to get information on state purchasing practices and policies, goods and services that the state buys, and tips on selling to the state. Vendors may use the same Web site address for inclusion on the bidders list for goods and services that the organization wants to sell to the state. A subscription with notification guarantees the organization will receive an e-mail message each time a state agency, including any campus of the University of Wisconsin System, posts a request for bid or a request for proposal in their designated commodity/service area(s) with an estimated value over $25,000. Organizations without Internet access receive paper copies in the mail. Increasingly, state agencies also are using VendorNet to post simplified bids valued at $25,000 or less. Vendors also may receive e-mail notices of these simplified bid opportunities.

2.0 PREPARING AND SUBMITTING A PROPOSAL

2.1 General instructions

The evaluation and selection of a contractor will be based on the information submitted in the vendor's proposal plus references and any required on-site visits or oral interviews. Failure to respond to each of the requirements in the RFP may be the basis for rejecting a response.

Proposal responses to requirements in sections 4.0, 5.0, and 6.0 must be complete and fully describe functions and processes related to the requirements. A response to each numbered statement is required, and should be labeled with the corresponding requirement number. References to previous responses are acceptable, as long as full, complete, and clearly identified responses are provided for each requirement. Proposal responses to these requirements must also clearly indicate whether the proposed system currently accommodates each requirement without modification or requires minor or significant system modification to meet the requirement. If modifications are required the proposer must specify the timeframe required to fully meet the requirement, from the time of contract. The Proposal Response Template provided in Appendix A must be used to submit responses.

Although the Department has not put a page limit on submissions, elaborate proposals (e.g., expensive artwork), beyond that sufficient to present a complete and effective proposal, are not necessary or desired.

The TPA functions specified in this RFP for statewide use cannot be hosted by an existing Managed Care Organization (MCO) or county waiver agency. Proposals received from existing MCOs and county waiver agencies will be rejected.

2.2 Incurring costs

The State of Wisconsin is not liable for any cost incurred by proposers in replying to this RFP.

2.3 Submitting the proposal

Proposers must submit an original and eight (8) printed copies, and one electronic copy in PDF format on a CD or DVD, of all materials required for acceptance of their proposal by **1:00 p.m. CT on 07/29/2009** to:

Long-term Care Infrastructure Project; Third Party Administration
Patricia McCollum, Procurement Manager
Department of Health Services
1 W. Wilson, Room 750
PO Box 7850
Madison, WI 53707-7850
E-Mail: Patricia.McCollum@wisconsin.gov

Proposals must be received in the above office by the specified time stated above. All proposals must be time-stamped as accepted by the Purchasing Office by the stated time. Proposals not so stamped will not be accepted. Receipt of a proposal by the State mail system does not constitute receipt of a proposal by the Purchasing Office, for purposes of this RFP.

To ensure confidentiality of the document, all proposals must be packaged, sealed and show the following information on the outside of the package:

- Proposer's name and address
- RFP for Long-term Care Infrastructure Project; Third Party Administration
- RFP 1677-DLTC-PM
- Due July 29, 2009 at 1:00 p.m.

An original plus three (3) printed copies, and one electronic copy in PDF format on a CS or DVD, of the Cost Proposal must be sealed and submitted as a separate part of the proposal. No reference to cost may be made in any other RFP response area. The outside of the envelope must be clearly labeled with the words “Cost Proposal, RFP RFP 1677-DLTC-PM and name of the vendor and due date. The cost proposal is due to the addressee on the due date and time noted above.

2.4 Proposal organization and format

Proposals should be typed and submitted on 8.5 by 11 inch paper bound securely. Proposals should be organized and presented in the order and by the number assigned in the RFP. Proposals must be organized with the following headings and subheadings. Each heading and subheading should be separated by tabs or otherwise clearly marked. The RFP response must include:

Cover page (DOA-3261), included as the cover sheet of this RFP.

Proposal Response Template, found in Appendix A.
- Response to Family Care Program requirements.
- Response to Family Care Partnership Program requirements.
- Response to Children's and Other Waiver Programs requirements.

Cost Proposal, found in Appendix B.

Required forms
- Designation of Confidential and Proprietary Information (DOA-3027), found in Appendix E.
- Vendor Information (DOA-3477), found in Appendix F.
- Vendor Reference (DOA-3478), found in Appendix G.

The vendor must submit its Cost Proposal according to the instructions provided in section 7.2. Failure to provide any requested information in the prescribed format may result in disqualification of the proposal. No mention of the cost proposal may be made in the response to the technical requirements of this RFP.

Proposers must include in their response a description of the firm's experience and capabilities in providing similar services to those required in this RFP. Be specific and identify projects, dates, and results. Also include audited financial statements from the last five (5) years that illustrate business solvency.

Proposers must include in their response, a list of three organizations with which the proposer has done business like that required by this solicitation within the last five (5) years. For each reference, the proposer must include the name, title, address, and telephone number of a contact person along with a brief description of the project or assignment which was the basis for the business relationship using the Vendor Reference Form in Appendix G. Proposers must also identify any vested interest that a reference has with the vendor that could be perceived as affecting the credibility of the report that the reference provide, e.g., a royalty agreement.

2.5 Multiple proposals

Multiple proposals from a vendor which propose different solutions to the same RFP requirements will be permissible; however, each proposal must conform fully to the requirements for proposal submission. Each such proposal must be submitted separately and labeled as Proposal # 1, Proposal # 2, etc. on each page included in the response.

2.6 Oral presentations and site visits

At the State's sole discretion, top scoring vendors based on an evaluation of the written proposal may be required to participate in interviews and/or site visits to support and clarify their proposals. The State will make every reasonable attempt to schedule each presentation at a time and location that is agreeable to the proposer. Failure of a proposer to interview or permit a site visit on the date scheduled may result in rejection of the vendor's proposal.

2.7 Withdrawal of proposals

Proposals shall be irrevocable until contract award unless the proposal is withdrawn. Proposers may withdraw a proposal in writing at any time up to the proposal closing date and time. To accomplish this, the written request must be signed by an authorized representative of the proposer and submitted to the RFP procurement manager. If a previously submitted proposal is withdrawn before the proposal due date and time, the proposer may submit another proposal at any time up to the proposal closing date and time.

3.0 PROPOSAL SELECTION AND AWARD PROCESS

3.1 Preliminary evaluation

The proposals will be reviewed initially to determine if submission requirements are met. Failure to meet submission requirements will result in rejection of the proposal. Failure to respond to all requirements in sections 4.0, 5.0, and 6.0 may result in rejection of the proposal. The State reserves the right to waive any minor irregularities in the proposal.

In the event that all vendors do not meet one or more of the submission requirements, the State reserves the right to continue the evaluation of the proposals and to select the proposal which most closely meets the submission requirements specified in this RFP.

3.2 Proposal scoring

Accepted proposals will be reviewed by an evaluation committee and scored against the stated criteria. A proposer may not contact any member of an evaluation committee except at the State's direction. The committee may review references, request interviews, and/or conduct on-site visits and use the results in scoring the proposals. The evaluation committee's scoring will be tabulated and proposals ranked based on the numerical scores received.

Responses to business requirements will be approximately 80% of the total RFP score. Each business requirement will be scored based on the extent to which it addresses the functional intent of the requirement as it relates to managed care.

Reviews of requirements responses and cost proposals will be done independently. A separate evaluation panel will be established to review cost proposals. The cost proposal will be approximately 15% of the total RFP score.

Various costing methodologies and models are available to analyze the cost information to determine the lowest cost to the agency. The agency will select one method for scoring costs and will use it consistently throughout its analysis of all the cost proposals. The selected methodology will be available when proposals are due by calling Patricia McCollum, Procurement Manager, at (608) 266-2628.

References provided by the proposers may be checked and any responses to reference questions will be approximately 5% of the total RFP score.

3.3 Evaluation criteria

The proposals will be scored using the following criteria:

Description	Points	Per Cent
Business System Requirements - Administration - Claims Processing - Fraud and Abuse Oversight - General Accounts Payable, Receivable, and Cash Receipting Functions - Eligibility and Enrollment Maintenance - Service Authorization Management - Provider Management - Grievance and Appeals Process Management - Customer Service and Support Functions - Data Maintenance and Data Integrity - Reporting - Additional Requirements for Family Care Partnership - Additional Requirements for Children's and Other Waivers	**1570**	**80**
Cost - Bulletin Level Development - Bulletin Level Set Up - Organization Level Contracting - PMPM - Optional Contracting Functions - Additional PMPM for Family Care Partnership - Additional PMPM for Children's and Other Waivers	**295**	**15**
References	**100**	**5**
Total:	**1965**	**100**

Except as permitted below, the evaluation committee must award at least 1260 points for the business requirements prior to having the cost proposal and references scored. A proposal that receives less than 1260 points on these sections will be ineligible for further consideration, unless the State decides in its sole discretion that the best interests of the

State would be served by passing a proposal on for further consideration if it scores within 95 percent of the threshold.

3.4 Right to reject proposals and negotiate contract terms

The State reserves the right to reject any and all proposals.

The State intends to use this RFP process to solicit for Third Party Administration services to be offered to our business partners. If contract negotiations with the State cannot be concluded successfully with the highest scoring proposer(s), the State may negotiate a contract with the next highest scoring proposer(s).

As explained in section 8.0, MCOs and county waiver agencies may negotiate further contract terms directly with the State's selected proposer(s).

3.5 Award and final offers

The State will compile the final scores for each proposal. The award will be granted in one of two ways. The award may be granted to the highest scoring responsive and responsible proposer(s). Alternatively, the highest scoring proposer or proposers may be requested to submit final and best offers. If final and best offers are requested by the State and submitted by the vendor, they will be evaluated against the stated criteria, scored and ranked by the evaluation committee. The award then will be granted to the highest scoring proposer(s). However, a proposer should not expect that the State will request a final and best offer.

3.6 Notification of intent to award

All vendors who respond to this RFP will be notified in writing of the State's intent to award the contract(s) as a result of this RFP.

After notification of the intent to award is made, and under the supervision of agency staff, copies of the proposals will be available for public inspection from 8:00 a.m. to 4:00 p.m. at the Department of Health Services. Vendors should schedule reviews with:

Patricia McCollum, Procurement Manager
Department of Health Services
1 W. Wilson, Room 750
PO Box 7850
Madison, WI 53707-7850
Phone: (608) 266-2628
FAX: 608-264-9874
E-Mail: Patricia.McCollum@wisconsin.gov

3.7 Appeals process

Notices of intent to protest and protests must be made in writing to the Secretary of the Department of Health Services. Protesters should make their protests as specific as

possible and should identify statutes and Wisconsin Administrative Code provisions that are alleged to have been violated.

Any written notice of intent to protest must be filed with

Karen Timberlake, Secretary
Department of Health Services
1 W. Wilson, Room 650
P.O. Box 7850
Madison, WI 53707-7850

and received in her office no later than five (5) working days after the notices of intent to award are issued.

Any written protest must be received within ten (10) working days after the notice of intent to award is issued.

The decision of the Secretary of the Department of Health Services may be appealed to the Secretary of the Department of Administration within five (5) working days of issuance, with a copy of such appeal filed with the procuring agency. The appeal must allege a violation of a Wisconsin statute or a section of the Wisconsin Administrative Code.

4.0 CORE BUSINESS SYSTEM REQUIREMENTS FOR ALL PROGRAMS

Requirements are organized into topical business process groups. Within each topic the requirements are further grouped into five (5) areas of pricing categories that correspond to the cost categories specified on the Cost Proposal Form in Appendix B. These cost categories are:

- Bulletin Level Development.
- Bulletin Level Set Up.
- Organization Level Contracting.
- Per Member, Per Month (PMPM).
- Optional Contracting Functions and Services.

These cost categories are defined for evaluation purposes to ensure accurate comparison between responses. These categories are more fully defined in section 7.2.

As stated in the general instructions in section 2.1, **responses to each requirement in sections 4.0, 5.0, and 6.0 must be complete and fully describe functions and processes related to the requirements**. Please describe policies, procedures, and/or methodologies, as appropriate, related to each requirement statement. Brief, yes/no answers are considered incomplete. A response to each numbered requirement is expected, and should be labeled with the corresponding requirement number. References to previous responses are acceptable, as long as full, complete, and clearly identified responses are provided for each requirement. Proposal **responses to these requirements must also clearly indicate whether the proposed system currently accommodates each requirement without modification or requires minor or**

significant system modification to meet the requirement. If modifications are required the proposer must specify the timeframe required to fully meet the requirement, from the time of contract. **The Proposal Response Template provided in Appendix A must be used to submit responses.**

4.1 Administration

Bulletin Level Setup

4.1.1 Provide 24 x 7 access to all contract-related documents maintained by the TPA.

4.1.2 Provide systems support to the contracting organization during extended work hours (e.g., 6:00 a.m. to 6:00 p.m., Monday through Friday).

Organization Level Contracting

4.1.3 Maintain electronic images of all claims-related service documents and provide for remote retrieval of these images including, but not limited to:
- Claims.
- Service authorizations.
- Receivables.
- New recipient set up.
- Provider additions and changes.

PMPM

4.1.4 Comply with HIPAA, ADA, and other federal and state regulations, and perform in accordance with contract terms and conditions.

4.1.5 Ensure electronic data transfers comply with HIPAA transaction format requirements, as applicable.

4.1.6 Ensure all functions operate in accordance with the HIPAA final and amended rules for security and privacy.

4.1.7 Conform to all state and federal confidentiality laws, and ensure that HIPAA data security, and privacy standards are met. Establish safeguards to protect the integrity and confidentiality of all data to assure information is not released without proper consent of the recipient. Track all releases of recipient personal data according to HIPAA privacy requirements.

4.1.8 Provide a flexible solution to effectively meet the requirements of upcoming HIPAA regulations and other national standards development. The system must accommodate changes with global impacts (e.g., implementation of ICD-10-CM diagnosis and procedure codes, eHR, e-Prescribe) as well as new transactions (e.g., ASC X12N 275: Additional Information to Support a Healthcare Claim) at no additional cost.

4.1.9 Provide a system that meets all requirements of currently issued National Provider Identifier (NPI) regulation.

4.1.10 Accept and process or generate the following HIPAA mandated batch and real-time transactions, other versions or standards that may be mandated and other transactions including, but not limited to:
- Health care claims (professional, institutional).
- Eligibility for a health plan.

- Health care services review - request for review and response.
- Health care claim status request and response.
- Benefit enrollment and maintenance.
- Health care claim payment/advice.
- Payroll deducted and other group premium payment for insurance products.
- Coordination of benefits for health care claims (professional, institutional).
- Functional acknowledgements.

4.1.11 Comply with all HIPAA transaction implementation guides.

4.1.12 Develop and use internal quality control procedures to monitor operations, data entry, and accuracy of processing for all functional areas.

4.1.13 Maintain cross-reference indexing of documents using recipient and provider identification numbers, as appropriate.

4.1.14 Establish and manage a user group for contracting organizations.

4.1.15 Participate in the DHS code committee and comply with decisions made by the committee; describe the qualifications of staff available for participation.

4.1.16 Participate in the DHS IT Workgroup, QA/QI workgroups, and any other DHS workgroups as requested by either the DHS or the contracting organization; describe the qualifications of staff available for participation in the IT and QA/QI workgroups.

4.1.17 Submit a business continuity plan that addresses, at a minimum, the following:
- Business continuity planning team, including a description of the organization, roles, and responsibilities.
- Criteria for executing the business continuity plan, including escalation procedures.
- Communication plan for critical personnel, key stakeholders and business partners.
- Business functions and dependent functions that must be maintained and services that must be restored, including key business information that would be required within 24 to 48 hours of a declared disaster or event.
- Recovery time for each major business function, based on priority.
- Business workflow and workaround procedures, including alternate processing methods and performance metrics.
- Recording and updating business events information, files, data updates, once business processes have been restored.
- Security procedures for protection of data.
- Ensure back-up copies are stored in a secure off-site location, and tests are routinely performed on back-up copies.

4.1.18 Submit a disaster recovery plan that includes, at a minimum, the following:
- Adequate back-up and recovery system in compliance with federal and state rules and regulations.
- Communication plan for critical personnel, key stakeholders and business partners.
- Periodic back-up which is adequate and secure for all computer software and operating programs; databases; files; and system, operations, and user documentation (e.g., electronic, non-electronic, incremental, full).
- Full and complete back-up copies of all data and software.

- Ensure back-up copies are stored in a secure off-site location, and tests are routinely performed on back-up copies.
- Policy and procedures for purging outdated backup data.
- Support the immediate restoration and recovery of lost or corrupted data or software resulting from the event of a disaster.
- Provide for a back-up processing capability at a remote site(s) from the primary site(s) such that normal payment processing and services can continue in the event of a disaster or major hardware problem at the primary site(s).

4.1.19 Provide sufficient transaction logging and data backup to allow the system(s) to be restored to any point in time. Restoration must ensure that all data are synchronized to prevent data corruption.

Optional Contracting Functions

4.1.20 Maintain electronic images of all contract-specified service documents and provide for remote retrieval of these images including, but not limited to:
- ISPs and case files.
- Grievances and appeals.
- Customer services inquiries.

4.2 Claims Processing

Bulletin Level Development

4.2.1 Accommodate claims submissions for atypical services from atypical providers through the use of a standard format and web based submission, designed for these types of community-based service providers. Indicate whether these claims for atypical services are, or can be, derived from pre-authorizations.

4.2.2 Accommodate provider remittance advice for atypical services from atypical providers through the use of a standard format and web based application, designed for these types of community-based service providers.

Bulletin Level Setup

4.2.3 Allow the submittal of decimal units and calculate payment based on the decimal versus rounding to a whole unit, as required by contracting organizations, and as directed by DHS policy.

4.2.4 Link subsequent submitted claims to denied claims when possible.

4.2.5 Periodically assess the fiscal impact of accepting Medicare crossover claims with the DHS and the contracting organization to agree upon the cost benefit of implementing the service or discontinuing the service. (Include frequency of assessments in your response.)

4.2.6 Implement restrictions on conditions to be met for a claim to be paid within the benefit packages including, but not limited to:
- Provider type.
- Provider specialty.
- Category of service (SPC).
- Recipient age.
- Recipient sex.

- Place of service.
- Procedure codes
- Modifiers.
- Diagnosis codes.

Organization Level Contracting

4.2.7 Implement DHS or contract specified restrictions on conditions to be met for a claim to be paid within the benefit packages (which include multiple waiver programs), including the ability to vary claim resolution actions (e.g., pay, pend, deny) by line of business and by error type.

4.2.8 Place edit and/or audit criteria limits on types of service by procedure code, by revenue code, by diagnosis code, by drug class, or based on specified data elements (e.g., recipient information, provider type and specialty, time periods, units, cost).

4.2.9 Implement restrictions on conditions to be met for a claim to be paid within the benefit packages based on contracting organization agreements including, but not limited to:

- Accident-related and insurance-related indicators for coordination of benefits.
- Required attachment indicators.
- Prior authorization indicators and effective date(s).
- DME limitations (i.e., life expectancy).
- Medicare Part A-covered service and effective date(s).
- Medicare Part B-covered service and effective date(s).
- Co-pay indicator and effective date(s).

4.2.10 Deduct either the provider reported or recipient liability amounts from claims, track remaining balances, and provide the capability to invoice recipients for the remaining monthly amount due, as directed by the contracting organization. Maintain the service charge data for encounter reporting.

4.2.11 Accept and deduct patient liability amounts from claim records and provide the ability to apply patient payment amounts, as directed by the contracting organization. Maintain the service charge data for encounter reporting.

PMPM

4.2.12 Establish a security policy and implement procedures that ensure the safety and confidentiality of all data transmissions between the contracting organization and the TPA.

4.2.13 Maintain reference data that supports claims edits, audits, and pricing logic in accordance with DHS and contracting organization policies. The application of these policies is subject to change; therefore, the edits, audits, and pricing methodologies described in this RFP shall not be considered an exhaustive list.

4.2.14 Maintain and update HIPAA mandated code sets, approved versions of HCPCS procedure codes, ICD-9-CM diagnosis and procedure codes, CDT procedure codes, revenue codes, Diagnostic Related Groups (DRG), and NDC drug codes.

4.2.15 Obtain regularly scheduled updates for HCPCS and CPT from CMS and AMA.

4.2.16 Maintain current and historical reference data, assuring that updates do not overlay or otherwise make historical information inaccessible.

4.2.17 Maintain a procedure file which contains five (5) character HCPCS, CDT, and CPT codes for medical-surgical, dental, and other professional services; two (2) character HCPCS and CPT modifiers; ICD-9-CM surgical, obstetrical, and miscellaneous diagnostic and therapeutic procedure codes; eleven (11) digit NDCs; four (4) digit revenue codes; and CDT dental codes. The procedure file will contain, by program, at a minimum, elements such as:

- Maximum procedure code history with a minimum of seven (7) years of status (active, inactive) code segments with effective begin and end dates for each segment.
- Coding values that indicate if a procedure is covered by Medicare, Medicaid, and/or other programs.
- Numerous parameters used in claims processing including, but not limited to: provider type, specialty, sub-specialty, recipient age and/or gender restrictions, place of service, modifier, co-pay indicator, eligibility aid category, emergency indicator, claim type, diagnosis, units of service, review indicator, and tooth number or letter.
- Multiple modifiers with different pricing factors applicable to each modifier.
- Two (2) digit place of service code.
- Procedures manually priced or reviewed.
- Information such as accident-related indicators for possible TPL, federal cost-sharing indicators, Medicare coverage, and allowed amounts.

4.2.18 The procedure code file must contain parameters used in claims processing including, but not limited to, provider type, specialty, recipient age and gender restrictions, place of service, modifier, claim type, diagnosis, units of service, and dates of service.

4.2.19 Maintain procedure code relationships to ensure claims for related procedures are not unbundled or coded differently (e.g., the same service submitted with a revenue code and a HCPCS code) and paid on the same day for the same individual.

4.2.20 Maintain revenue code files with a data set that contains, but is not limited to:

- Maximum revenue code history with a minimum of seven (7) years after the end date of status code segments with effective begin and end dates for each segment.
- Numerous parameters used in claims processing including but not limited to: provider type, specialty, sub-specialty, recipient age and/or gender restrictions, claim type, diagnosis, units of service, and review indicator.
- Information such as accident-related indicators for possible TPL, federal cost-sharing indicators, Medicare coverage, and allowed amounts.

4.2.21 Maintain a drug file using the NDC, which can accommodate regular, periodic updates from a contracted drug pricing service, as specified by contracting organizations.

4.2.22 Maintain a diagnosis file of medical diagnosis codes utilizing the three (3), four (4), and five (5) character ICD-9-CM coding system, which can maintain relationship edits for each diagnosis code, including:

- Age.
- Gender.
- Begin date.
- End date.

- Add date.
- Audit trail.
- Place of service.
- Prior authorization.
- Inpatient length of stay criteria.
- Emergency indicator.
- Trauma indicator.
- Description of the diagnosis.
- Accident indicator.
- DRG Medicare code.
- Sterilization indicator.
- Family planning status.
- Primary and secondary diagnosis code usage.
- Review indicator.
- Indicators associated with selected parameters to designate whether they should be included, excluded or disregarded in claims and/or encounter processing.

4.2.23 Maintain separate tables by program to assign state-defined SPC codes to encounter transactions.

4.2.24 Define and enforce the use of appropriate procedure coding schemes (e.g., HCPCS, ICD-9-CM, CDT) and/or diagnosis coding schemes (e.g., ICD-9-CM) based on parameters such as claim type, provider type and specialty, place of service, or service rendered.

4.2.25 Establish processes, or subscribe to services, that evaluate claims submissions for the need to enhance the unbundling and other data relationship protocols.

4.2.26 Maintain positive and negative data relationships. The types of relationships shall include, but are not limited to, procedure to provider types and specialties, procedure-to-procedure, procedure to diagnosis, procedure to recipient age, and procedure to recipient gender.

4.2.27 Maintain current and historical recipient and provider names and their assigned identification numbers. Provide an automated link to claims for the recipient and provider under current and historical names and identification numbers.

4.2.28 Incorporate audit trails to allow information on all transactions to be traced through all processing stages with the ability to trace data from the final place of recording back to its source.

4.2.29 Process third party coverage updates received from certifying agencies, providers, and as a result of errors in processing insurance company file matches. (Include frequency of updates in your response.)

4.2.30 Maintain all third party resource information at the recipient-specific level including, but not limited to:

- Carrier name and identifier.
- Policy number and group number.
- Effective date of coverage and end date of coverage, if applicable.
- Add date, change date and verification date of insurance.
- Source of the insurance information identifier.
- Type of verification of insurance identifier.

- Policy holder name, address, SSN, date of birth, relationship to insured, employer name and address.
- Specific information on types of services covered by the policy, as defined by the contracting organization.
- Part A and/or Part B Medicare.
- Medicare Managed Care plan.
- Medicare Supplemental plan.
- Drug Plan.
- Tricare.

4.2.31 Maintain a file of all carriers during the life of the contract that includes, but is not limited to:
- Carrier name and identifier.
- Technical contact name and phone number.
- Corporate contact name, address and telephone number.
- Claims submission address and phone number.
- Indicators of coverage by defined categories of services as applicable.
- Active or inactive status.

4.2.32 Maintain all third party resource information at the recipient-specific level including, but not limited to, names, identifiers, unlimited number of other insurance plans, policy and group numbers, coverage dates, sources, services, and payers. Provide third party coverage investigation services, based on injury-related diagnoses, and conduct regular queries to proactively update recipients' other insurance information.

4.2.33 Maintain a minimum of twenty-four (24) months of online claims history, including records of all claim determinations, accounting, and reporting.

4.2.34 Accept COB information from the DHS, MCOs, county waiver agencies, other contracting organizations, and other private, state, and federal sources, and process third party coverage information from all sources according to defined criteria.

4.2.35 Coordinate benefits with other insurance benefits including, but not limited to:
- Subrogation.
- Worker's Compensation.
- Medicare.
- Medicaid.
- Private health, long-term care, casualty, or liability.

4.2.36 Maintain multiple third party coverage information for individual recipients for all periods of eligibility.

4.2.37 For each edit and/or audit exception, provide all resolution information including, but not limited to, a resolution code; an override, force or deny indicator; and the date the error was resolved, forced, or denied, and by whom. All claims must carry sufficient information to provide a complete online audit trail of all exception processing. These data elements shall be maintained in the claims history to support provider and claims processing audits.

4.2.38 Maintain program specific claim filing time limits and enforce them in the claims processing edit processes. Calculate claims processing time from valid claim receipt date. Claim filing time limit may vary by program and may be over-ridden by the decision of the contracting organization.

4.2.39 Support and maintain a cross reference file that connects standard codes, rates, and COB information used by the long term care, waiver, and other DHS programs for pre-authorizations, claims processing, encounter reporting, research, and analysis, and benefit packages.

4.2.40 Receive claims in a variety of mediums including, but not limited to, HIPAA-compliant electronic formats and paper documents from providers, billing services, contracting organizations, Medicare carriers and intermediaries, and coordination of benefits contractors.

4.2.41 Process electronic claim transactions, tapes, and discs within one (1) business day of receipt.

4.2.42 Identify, upon receipt, each claim record and adjustment with an ICN that designates the origin of claim record, year and date of receipt. Attachments should carry the ICN of the relevant claim record with a suffix or other indicator identifying it as an attachment.

4.2.43 Accept paper and HIPAA-compliant electronic attachments and link to the original claim using the ICN. Attachments should carry the ICN of the claim record with a suffix or other indicator identifying it as an attachment.

4.2.44 Assign an ICN to every claim, transaction, attachment, and adjustment and optically store (scan) every claim, attachment, and adjustment within one (1) business day of receipt at the contractor site. This includes controlling documents without sufficient information to index.

4.2.45 Deny or reject all electronic claims transactions that do not comply with HIPAA mandated standards, with the exception of agreed upon transactions for atypical claims.

4.2.46 Accept additional claim inputs, including but not limited to:
- Claims for Medicare coinsurance and deductible (crossover claims), in both paper and electronic formats.
- Attachments required for claims adjudication, including coordination of benefits and Medicare explanation of medical benefits.
- Non-claim specific financial transactions such as fraud and abuse settlements, insurance recoveries, and cash receipts.
- Subrogation.
- Worker's Compensation.
- Reinsurance payments.

4.2.47 Establish controls to ensure that no paper claims and attachments, tapes, discs, or other data are misplaced, lost, or duplicated after receipt.

4.2.48 Edit all required data elements for presence and validity on all entered claims, according to DHS specifications, as directed by the contracting organization.

4.2.49 Process claims according to defined benefit packages and pre-authorization requirements.

4.2.50 Maintain benefit package information, including program coverage requirements, edits and audits, and provide data (or access to data) for analysis.

4.2.51 Maintain identifiers and taxonomy for provider types and specialties participating in various benefit packages including atypical and non-licensed, but program-approved, service providers.

4.2.52 Maintain information on benefit package coverage including, but not limited to, recipients; providers; programs; place of service; procedure, modifier, and diagnosis codes; services authorized under each benefit package; and services included or excluded for each benefit package.

4.2.53 Maintain system capability and flexibility to accurately accommodate benefit package changes within time frames specified or approved by the contracting organization.

4.2.54 Support the administration of a variety of benefit packages and claims processing and program administration requirements.

4.2.55 Track claims and other documents that are returned to the provider or other source including, but not limited to, the date returned, and the reason for the return.

4.2.56 Edit to ensure all required attachments are present.

4.2.57 Pend or deny claims for specified time frames when no matching attachments (e.g., activity reports, follow-up reports) are provided.

4.2.58 Perform adjudication of claims, including special or atypical claims, using edits, audits, and processing rules in accordance with specified guidelines (e.g., deny, override). Describe categories of edits and/or audits available.

4.2.59 Systematically accept global changes to suspended claims, based on defined criteria, and release claims for editing.

4.2.60 Edit to ensure other insurance benefits have been satisfied and maximized, and a valid insurance denial attachment is present when it is required.

4.2.61 Edit for recipient eligibility and enrollment on date(s) of service.

4.2.62 Edit for valid billing, attending, rendering, referring, and/or prescribing provider number or NPI, as appropriate.

4.2.63 Edit for prior authorization requirements, and verify the claim services match an active prior authorization for those services, independent of the pre-authorization identification number.

4.2.64 Edit to assure the claim is from an authorized provider. Generate notifications when a non-authorized provider is submitting a claim.

4.2.65 Edit prior authorized claims and reduce billed units, dollars, or days' supply, based on authorization limits and the recipient's historical consumption of services.

4.2.66 Calculate and recoup payments made for services that exceed the original authorized units, dollars, and/or services.

4.2.67 Perform automated crosschecks and relationship edits and audits on all claims.

4.2.68 Perform logical claims sequencing of edits and audits.

4.2.69 Perform automated audit processing using history claims, suspended claims, in-process claims, and same cycle claims.

4.2.70 Follow-up with carriers on a schedule specified by the contracting organization when insurance coverage is not present on the recipient file but a TPL payment is shown on the claim. Update other insurance records as appropriate, and

notify the contracting organization of any changes to other insurance coverage information.

4.2.71 Edit and/or audit for potential and exact duplicate claims, including cross-references between group and rendering providers; multiple provider locations; and across provider types and categories of service.

4.2.72 Identify and track all edits and audits posted to the claim in the entire processing cycle. Provide reports to allow the analysis of edit and audit impact on claims in various categories.

4.2.73 Maintain an audit trail for each claim record that shows each stage of processing, the date the claim entered each stage, and any edit and/or audit codes posted to the claim at each step in processing.

4.2.74 Calculate the allowed claims payment amount according to date specific pricing and Medicare and Medicaid approved reimbursement methodologies.

4.2.75 Identify potential and existing COB opportunities, including Medicare, and deny the claim when it is for a covered service under another insurance resource, for applicable claim types (e.g., an atypical chore service would not be denied where other health insurance exists).

4.2.76 Maintain a record of the related benefit package for each claim.

4.2.77 Maintain the original billed amount, calculated allowed amount, any manually priced amount, and the actual payment amount on the claim history record.

4.2.78 Return claims to providers that do not meet approved screening criteria.

4.2.79 Establish claims control balancing processes.

4.2.80 Identify and monitor operators who are authorized to force or override an edit and/or audit based on individual operator identification and/or authorization level.

4.2.81 Perform claims reconciliation between claim receipts and batch processing input.

4.2.82 Retain paper documents and claims until the document image quality has been verified, the batch is fully adjudicated, and the retention schedule has lapsed.

4.2.83 Assure that Medicare crossover claim and adjustment media types are uniquely identified on all standard claim statistic reports.

4.2.84 Identify and develop recommendations regarding policy and/or adjudication guidelines that are unclear and/or cause problems in adjudicating claims.

4.2.85 Maintain claims that have been purged from active claims history indefinitely on a permanent history archive with key elements of the history claim.

4.2.86 Identify and advise the contracting organization of proposed changes to edits and audits to enhance processing and efficiency.

4.2.87 Process individual, mass, and gross adjustments submitted as HIPAA-compliant electronic transactions and as paper transactions.

4.2.88 Provide a flexible mass or individual adjustment process that can be controlled by various parameters or selection criteria (e.g., procedure code, provider ID) for all claims.

4.2.89 Conduct retrospective review and identify and recover payments for claims processing errors.

4.2.90 Perform adjustments to original and adjusted claims and maintain records of all previous processing. Perform all claim adjustment activities according to GAAP. (See the encounter reporting implementation guide found on the DHS web site at: http://dhs.wisconsin.gov/ltcare/Encounter for details on making adjustments.)

4.2.91 Prevent multiple adjustments to a single claim record. (See the encounter reporting implementation guide found on the DHS web site at: http://dhs.wisconsin.gov/ltcare/Encounter for details on making adjustments.)

4.2.92 Suspend and adjust provider claims in the normal claims processing sequence, so that facilities providers can receive partial payment for payable lines and only resubmit suspended portions in the next cycle.

4.2.93 Update provider payment history and recipient claims history with all appropriate financial records and reflect adjustments in subsequent reporting, including claim specific and non-claim specific recoveries. Refund non-claim specific financial payments and recoveries, as defined by individual agreement.

4.2.94 Generate adjustment reports according to specifications, as defined by individual agreement.

4.2.95 Designate to which fiscal year adjustments and other financial transactions are to be reported. Accommodate cut-off requirements for fiscal reporting, as specified.

4.2.96 Maintain all claim history (original claims and all previous adjustments) with all of the original information including, but not limited to, the original paid amount, the adjusted amount, the full amount gross calculated, and the net amount calculated.

4.2.97 Identify all claim records affected by retroactive rate adjustments, create adjustment records for them, reprocess them, and maintain a link between the original and adjusted claim.

4.2.98 Re-edit, re-price, and re-audit each adjustment, including checking for duplication against other regular and adjustment claim records, in history and in process.

4.2.99 Identify and calculate payment amounts according to established rules and rates. Accommodate these and any future pricing methods:

- Rate on file or billed amount, whichever is less.
- Percentage of rate on file.
- Anesthesia Pricing using a formula.
- DRG pricing.
- Procedure code modifier pricing.
- Manual pricing.
- Nursing home daily rate.
- Nursing home prospective payment system.
- Resource Utilization Groups (RUGs)
- Long Term Acute Care Hospital (LTACH)
- Facility specific per diem rate.
- Outpatient hospital rate per visit (day).
- Outpatient prospective payment system.

- Crossover claim pricing, including Part B pricing reductions.
- Incentive payment pricing.
- MAC, EAC, or AWP minus a percentage for drugs plus dispensing fee per prescription. These are prescription pricing methodologies.
- Individual waiver program pricing methodologies.

4.2.100 As needed, apply all of the above mechanisms according to:
- Geographic area by county or ZIP code of provider or recipient.
- Individual provider number.
- Provider number.
- Individual recipient identification number.
- Recipient age, gender, or aid category.
- Provider type or specialty.

4.2.101 Adjust benefits and service limitations (e.g., prior authorization) based on claims adjustments and modify pre-authorization amounts available, as appropriate.

4.2.102 Ensure suspended or pended claims are re-edited based on pre-authorizations and other claims edit criteria in effect for the dates of service or processing dates, as appropriate.

4.2.103 Provide reports of the ICNs of claims selected for mass adjustments online to determine the impact of the adjustment prior to the actual adjustment process.

4.2.104 Enter claim adjustment transactions received on paper documents.

4.2.105 Accommodate date sensitivity editing with iterations of data for all maintained data fields.

4.2.106 Provide the capability for providers to receive the remittance advice on paper, electronically, or both.

4.2.107 Generate and display approved information messages on the banner page of the paper remittance advice.

4.2.108 Generate a remittance advice, even if the payment amount is zero.

4.2.109 Generate a simplified provider remittance advice for atypical providers that reflects data specific to atypical services.

4.2.110 Provide the ability to collect the contracting organization's internally provided case management services data (e.g., case management) for reporting purposes but suppress payments for these services.

4.2.111 Meet all paper claims and adjustment processing standards set by the state or the federal government. These standards include processing claims as follows:
- Ninety percent (90%) of all claims shall be processed within ten (10) calendar days of receipt.
- Ninety-five percent (95%) of all claims shall be processed within twenty-one (21) calendar days of receipt.
- Ninety-nine percent (99%) of all claims shall be processed within thirty (30) calendar days of receipt.
- One hundred percent (100%) of all claims shall be processed within ninety (90) calendar days of receipt.

4.2.112 Maintain the contracting organization's provider remittance advice process separately from other lines of business, as specified in individual agreements.

4.2.113 Meet all electronic claims and adjustment processing standards set by the state or the federal government. These standards include processing claims as follows:
- Ninety percent (90%) of all claims shall be processed within five (5) calendar days of receipt.
- Ninety-five percent (95%) of all claims shall be processed within ten (10) calendar days of receipt.
- Ninety-nine percent (99%) of all claims shall be processed within fifteen (15) calendar days of receipt.
- One hundred percent (100%) of all claims shall be processed within twenty (20) calendar days of receipt.

4.2.114 Accept contracted rate information from the contracting organization. Price provider claims using provider specific and program specific contracted rates for recipients. Also, price based on individual pre-authorization negotiated rates, as required by the contracting organization, or based on Medicaid rates.

4.2.115 Maintain multiple nursing facility (long-term care) rates, per provider.

4.2.116 Accept rates for services including, but not limited to:
- Individual.
- Pre-authorization.
- Provider.
- County.
- Program.

4.2.117 Maintain pricing data based on:
- Fee schedules by benefit package.
- Provider-specific usual and customary charges.
- Procedure modifiers (e.g., DME).
- Per diem rates.
- Self-directed support services by budget or dollar limit.
- DRGs.
- Multiple-level dispensing fee for drugs (e.g., compound, enhanced, repackaging allowance).
- MAC, EAC, AWP, AWP- ten percent (10%), and direct pricing for drugs.
- Case-mix rates for LTC (in addition to facility-specific per diem rates by level of care).

4.2.118 Provide the ability to compare rates between waiver and Medicaid services in order to pay at the most cost-effective rate, as directed by the contracting organization.

4.2.119 Generate expenditure, eligibility and utilization data to support budget forecasts, monitoring and health care program modeling.

4.2.120 Accommodate retroactive changes, future changes, and expanded pricing processes with no additional cost.

4.2.121 Continue claims processing services for 180 days after termination date for dates of service prior to the termination date at no additional cost. During and at the end of the termination run-out period, the contractor will fully cooperate in the transfer of all records and reports, including computer records and other data as requested by contracting organization within 10 business days of the request, at no additional cost.

Optional Contracting Functions

4.2.122 Receive and process regularly scheduled files from insurance companies to identify and update recipient records based upon third party payer information.

4.2.123 Receive and process Worker's Compensation information on a periodic basis, as determined by the contracting organization.

4.2.124 Identify and advise the DHS and the contracting organization of code set changes including proposed edit and audit changes.

4.2.125 Provide access for research purposes to a cross reference between local codes, state codes, and national codes used for claims adjudication.

4.2.126 Accept historical claims data from other vendors (e.g., cost share, claims run in for take-over cases). Provide the ability to accept and process take-over claims inventory and transition responsibility of that inventory.

4.2.127 Provide the contracting organization with the ability to submit claims on behalf of providers, if requested.

4.2.128 Provide the contracting organization with the flexibility to review claims that the TPA intends to return to the provider for more information.

4.2.129 Pend claims and notify the contracting organization of unauthorized services as specified by service agreements.

4.2.130 Accommodate atypical coordination of benefit requirements based on contracting organization or program agreements (e.g., pay and pursue for other insurance, subrogation or workers' compensation).

4.2.131 Interface with Medicare contractors to exchange eligibility information, and other data as specified by the DHS or the contracting organization, to use in matching information for Medicare crossover claims, if applicable.

4.2.132 Report to the contracting organization any problems related to receipt of automatic crossovers and adjustments (e.g., electronic crossovers received directly from the Medicare intermediary or carrier) that impact the timely processing of claims.

4.2.133 Schedule meetings with the contracting organization and Medicare contractors when necessary to resolve issues related to receipt or processing of Medicare crossover claims.

4.2.134 Accommodate the claim history reconciliation of provider pre-payments by tracking pre-paid amounts as receivables, adjusting claims history as service claims are presented and reflecting the adjustments through the EOB process. The processes need to maintain the integrity of the financial posting process.

4.2.135 Provide the flexibility to establish payment time frames by provider, within the performance standards.

4.3 Fraud and Abuse Oversight

Organization Level Contracting

4.3.1 Develop contracting organization defined reports to support audit programs that include the recipients being audited, the services being audited, and the date range of services for any given recipient.

PMPM

4.3.2 Perform data matches to identify potential fraud and abuse occurrences, as defined by the contracting organization.

4.3.3 Track complaints and referrals from outside parties and agencies regarding recipients or providers. Track dispute resolutions.

4.3.4 Provide an automated fraud and abuse profiling system for the ongoing monitoring of provider and recipient claims to detect patterns of potential fraud, abuse, and excessive billing. The system must be able to perform targeted or intensive monitoring of specific providers, services, procedures, diagnoses, and/or recipients over time. Monitoring includes, but is not limited to:

- Bundling and unbundling.
- Medically unnecessary services.
- Overuse of services for all claims, provider types, and recipient categories.
- Medically unnecessary care.
- Fraud and abuse by providers.
- Fraud and abuse by recipients.
- Fraud and abuse by TPA, contracting organization, and any other contracted employees.
- Inappropriate billing practices.
- Clinically inappropriate or unnecessary utilization compared to nationally recognized practice parameters.

4.3.5 Profile, track, and analyze paid claims data to identify the following:

- Potential fraud and abuse by providers, recipients, and employees.
- Inappropriate and excessive billings and over payments, including unethical billing practices, upcoding, unbundling, and other creative billing practices, and violations of provider instructions conveyed via applicable Medicare, Medicaid, and contracting organization handbooks and bulletins.
- Access, quality, use, and cost of all Medicare and/or Medicaid covered health care services and key utilization management issues.

4.3.6 Identify cases with the highest potential for fraud and/or abuse.

4.3.7 Perform provider billing pattern analysis of illogical or inappropriate billing across any health care setting.

4.3.8 Generate a regularly scheduled report on potential fraud and abuse activities, as defined by individual agreement.

4.3.9 Represent the contracting organization as necessary and provide testimony for findings from investigations that are appealed and/or for which hearings or trials are conducted.

4.3.10 Provide operations support for audit programs. The audit support must include for review, at a minimum, claim information; payment, partial payment, and

recoupment information; potential duplicate claims information; eligibility and enrollment information; and other insurance information.

4.3.11 Provide various contracting organization defined reports to support audit programs, both prior to and after the audit.

4.3.12 Generate regular, periodic audit status reports based on specifications defined by the contracting organization.

4.3.13 Notify the contracting organization when potential fraud is suspected or when it is reported by a recipient, as appropriate.

4.4 General Accounts Payable, Receivable, and Cash Receipting Functions

Organization Level Contracting

4.4.1 Customize the process of pending or withholding payments on adjudicated claims and transactions according to contracting organization policies, procedures and/or requests, and provide authorized users with access to pended transaction data by claim type, media, payee type and identification number, program area, amount, fund code, and category of service (e.g., when a provider receives payment from both the contracting organization and an insurance carrier, and when provider does not respond in a timely manner).

4.4.2 Customize the release of pended claims and/or transactions manually or automatically, as specified by individual contracting organization agreement and by provider agreement. Provide the ability to:
- Manually release pended claims and/or transactions.
- Automatically recycle pended claims and/or transactions.
- Control the timing of the release of pended claims and/or transactions.

4.4.3 Provide the ability to offset a provider payment to recoup receivables due from that provider, at the recipient service level, as specified in contracting organization agreements. Provide notification to the provider that a refund is due prior to the offset.

PMPM

4.4.4 Establish and monitor a system for generating payments according to state and federal guidelines, both automatically (system generated) or manually, using EFT or manual distribution as appropriate.

4.4.5 Run required cycles of automated payment and refund processing on schedules approved by the contracting organization.

4.4.6 Maintain authorized payment and refund processing cycles.

4.4.7 Maintain an authorized system for voiding, stopping, replacing, stale dating and reissuing payments and refunds, and establish agreed upon communication protocols for requesting voids, stop payments, and reissues.

4.4.8 Void, stop payment, adjust, replace and reissue payments and refunds, as stipulated by contracting organization policies, procedures and requests.

4.4.9 Establish and maintain a process for generating check registers at the end of each designated payment cycle.

4.4.10 Establish and maintain security for printed checks and check stock during the storage, print and mailing processes in accordance with GAAP.

4.4.11 Maintain an audit trail of all updates to accounts payable transactions.

4.4.12 Establish and maintain internal auditing procedures and cycles in accordance with GAAP.

4.4.13 Establish security and internal control measures for maintaining the confidentiality of the information contained in the accounts payable and receivable systems.

4.4.14 Maintain electronic (EFT) payment and refund transaction information.

4.4.15 Establish and reconcile a bank master file for documenting all payments and refunds issued and their current status. Establish a claims receivable process to tie out and balance claims receivables to claims history adjustments. Provide inventory and aging reports for un-reconciled receivables.

4.4.16 Establish and maintain a process for producing and submitting accounts payable reports and payment summaries.

4.4.17 Meet all industry and U.S. Postal Service standards regarding electronic fund transfers (EFT) and paper check distribution.

4.4.18 Withhold provider payments based on state or federal levy requests.

4.4.19 Establish and maintain separate bank accounts for multiple programs at an approved bank.

4.4.20 Suppress the processing of zero-payment checks without suppressing the associated remittance advice within the accounts payable system, and create a report of zero-payments for each payment cycle.

4.4.21 Maintain a system for tracking payer transactions received (e.g. the refund of an overpayment), making adjustments to the account receivables accordingly, and making appropriate adjustments to service pre-authorization records.

4.4.22 Maintain a system that tracks accounts receivable data and pended amounts. The summary level data shall consist of calendar week-to-date, month-to-date, year-to-date, and the state and federal fiscal year-to-date totals.

4.4.23 Monitor status of outstanding accounts receivables and generate letters for outstanding accounts receivables.

4.4.24 Pend accounts receivable collections for bankruptcies and deaths. Generate reports for Medicaid estate recovery as defined by the DHS.

4.4.25 Collect appropriate accounts receivables based on bankruptcy court resolution.

4.4.26 Establish and maintain a recoupment process that includes supporting documentation for instances of overpayments, incorrect payments or payments to ineligible payers.

4.4.27 Maintain multiple receivable accounts by payer.

4.4.28 Provide the ability to accept receivables from a single provider and split and apply to multiple payers accounts.

4.4.29 Establish and maintain security and internal control measures for maintaining the confidentiality of the information contained in the accounts receivable system.

4.4.30 Provide the ability to link post payment recovery to the original claim.

4.4.31 Accept and process HIPAA-compliant electronic remittance advice from payers for posting payments received.

4.4.32 Operate and manage the accounts receivable functions in compliance with GAAP.

4.4.33 Perform accounts receivable functions to include, but not limited to:
- Collection of overpayments.
- Maintenance of payments due as the result of audits and peer review findings.
- Reconciliation of claims receivables to claims history adjustments.
- Adjustment of benefit or pre-authorization records to reflect any refunds of previously decremented service authorizations.

4.4.34 At minimum, process financial transactions including, but not limited to:
- Accounts receivables.
- Recoupments.
- Manual checks.
- Application of checks received to accounts receivable.
- Application of checks to a payer's payment history file.
- Check stop payment and EFT reversals.
- Check voids and void re-issue and EFT reversals.

4.4.35 Establish and maintain financial processing and adjustment processing policies and procedures and posting instructions.

4.4.36 Issue initial and follow-up letters regarding claims-related receivables according to DHS guidelines, in accordance with individual contracting organization agreements.

4.4.37 Produce payer payment reports after each payment processing cycle.

4.4.38 Designate financial status of all cash receipt transactions including, but not limited to, record creation, documentation, and maintenance.

4.4.39 Update financial claims history to reflect cash receipts.

4.4.40 Generate cash receipt reports and maintain supporting documentation.

4.4.41 Identify and track all cash receipts by type and/or source.

4.4.42 Deposit all cash receipts by type and/or source within 48 hours.

4.4.43 Provide accounting processes for non-claim specific financial transactions (e.g., member share payment collection transactions) including, but not limited to:
- Application of collections received to cash receipts and satisfaction of accounts receivable.
- Application of refunds received to a payer's payment history file, with reconciliation processes to assure all receipts are credited to the historical records.
- Institutional liability amounts owed by recipients.
- Date of service, date of adjudication, date of payment.

4.4.44 Provide secure banking and financial information procedures.

4.4.45 Track and maintain all information required for generating the annual 1099 income report.

Optional Contracting Functions

4.4.46 Generate post payment bills to be sent to Medicare, intermediaries, and insurance companies in formats specified by the contracting organization. This includes HIPAA-approved formats, including NCPDP, CMS-1500, and UB-04 claim forms.

4.4.47 Perform accounts receivable functions to include, but not limited to:
- Collection of member share including cost share, room and board, spend down, and voluntary contributions; and parental payment limit.
- Tracking spend down limits by recipient.
- Coordination of member share amounts paid to multiple sources.

4.4.48 Create invoices and notices, including recipient cost share, according to schedules defined by the contracting organization.

4.4.49 Collect member share payments, apply the payments, monitor the process and report to the contracting organization on the collections at a payer and summary level, maintain collection payment transaction information. At a minimum, the cost sharing function must:
- Accept and process cost sharing information from the DHS or the contracting organization.
- Reduce provider payments as appropriate based on members'/participants' cost sharing information, or reflect cost sharing in claims history transactions.

4.4.50 Maintain a collection process for cost share, room and board, voluntary contributions, parental payment limit, and spend down payments to the contracting organization, as directed by the contracting organization. Receive and process collection payments including, but not limited to, the following types:
- Checks.
- EFT transactions.
- Money orders.
- Cash.

4.5 Eligibility and Enrollment Maintenance

PMPM

4.5.1 Receive eligibility information in a variety of mediums including, but not limited to, HIPAA-compliant electronic formats, and paper documents.

4.5.2 Maintain recipient data to support processing of long term care claims including, but not limited to:
- Level of Care.
- Level of Care effective dates.
- Spend down amount.
- Recipient location data.
- Case management unit.
- County of residence.

- Specific office locations within a county.
- County of fiscal responsibility.

4.5.3 Accept HIPAA compliant eligibility/enrollment information from the DHS, contracting organization, and/or CMS as directed by individual agreements.

4.5.4 Provide controls to prevent retroactive adjustments to eligibility and/or enrollment dates. Provide limited override capability with automatic claims and authorization adjustments and/or reports in the event retroactive changes are made.

4.5.5 Maintain recipient eligibility status including enrollments and disenrollments, including dates and reasons. There may be multiple entries for one recipient.

4.5.6 Produce reports on enrollments and disenrollments, as specified by the contracting organization.

4.5.7 Accept and process claims based enrollment dates that occur on the date of eligibility rather than the first of the month.

4.5.8 Provide enrollment reports calculating enrollment days for programs which enroll on the eligibility date, versus the first of the month.

4.5.9 Accommodate the capture of county of fiscal responsibility as an enrollment data element, which may change over the course of a program enrollment period.

4.5.10 Create and maintain a unique recipient identification number for each recipient with capability to store identification numbers that are up to fourteen (14) characters in history, as directed by the contracting organization agreements.

4.5.11 Maintain current and historical recipient names and assigned identification numbers, and provide an automated link to claims for the recipient under current and historical names and identification numbers.

4.5.12 Support regular, periodic enrollment reconciliation activities by the contracting organization, as specified in individual agreements.

Optional Contracting Functions

4.5.13 Accept recipient eligibility and provide secure update capability to designated contracting organization staff.

4.5.14 Provide the ability to issue ID cards and enrollment information packets to members/participants including the ability to reflect multiple eligibility dates for Medicare integrated program members, tracking multiple identification numbers accordingly.

4.6 Service Authorization Management

PMPM

4.6.1 Accept service prior authorizations and amendments by paper, fax, telephone, or electronic transmissions in the appropriate HIPAA-compliant manner.

4.6.2 Capture, and provide access to, prior authorization data which includes, at minimum, the following:

- Prior authorization number.

- Recipient information.
- Service Information, including: requested start date, rendering provider number, coding information, modifiers, place of service, description of service, quantity authorized, quantity used, dollar amount charged, begin and expiration date.
- Receive date.
- Date approved.
- Expiration date.
- History of all actions taken, including amendments.
- Date of last change, ID of person changing, and information changed.
- Review date.
- Date adjudication notice sent to provider and recipient.
- Authorizing person identification.
- Free-form text area for special considerations, along with a flag to allow identification of authorizations with special considerations.
- A text area which will be printed on the prior authorization notice, using predefined messages as well as unique messages (e.g., informing providers of cases where the original code requested was changed to reflect the diagnosis on the authorization).

4.6.3 Provide regular reports of all changes made to prior authorization data to the contracting organization including, but not limited to, date of change, ID of person making the change, and the specific information that has been changed.

4.6.4 Provide the ability to match claims to specific pre-authorized services (not just to a pre-authorization identification number), matching and decrementing pre-authorizations based on provider encounter specific data.

4.6.5 Implement and maintain an automated process to link hard copy prior authorization attachments, such as x-rays and dental models, with the corresponding electronic prior authorizations.

4.6.6 Update prior authorization records based on claims processed to indicate that the authorized service has been used or partially used, including units and dollars, during each prior authorization request period. This includes the restoration of authorized units based on claims adjustments.

4.6.7 Process prior authorizations for non-covered services according to guidelines defined by the contracting organization. For example, in some cases a contracting organization may decide to allow specified service circumstances (e.g., type and dollar threshold) without a prior authorization.

4.6.8 Edit prior authorizations for the presence of required data to include, but not limited to, the following:

- Valid provider ID and eligibility.
- Valid recipient ID and eligibility.
- Valid procedure and diagnosis codes.
- Presence of required claim type-specific data on the prior authorization.
- Covered service.
- Duplicate authorization check to previously authorized or previously adjudicated services (including denials) and duplicate requests in process.
- Valid referring or prescribing provider, if required.

4.6.9 Identify errors on prior authorizations with edits and/or audits that specify the field in error, suspend prior authorizations containing errors, and notify the contracting organization of the prior authorization suspense status. Notify the contracting organization with results of prior authorization clerical and/or clinical reviews and request additional information that is required from the contracting organization.

4.6.10 Automatically close prior authorization records after a specified time period.

4.6.11 Maintain provider-specific prior authorization history.

4.6.12 Provide the capability for the contracting organization staff to analyze and report, at minimum, the following:

- Claims applied against a prior authorization.
- Prior authorization records and amendments meeting specified criteria.
- Twenty-four (24) months online prior authorization history and/or other services whose approval period exceeds that period.
- Prior authorization, expenditure, and service patterns of billing and rendering providers.
- Prior authorization and adjudication characteristics and results, by provider type, by recipient type, by place of service, type of service, by named provider or recipient, by diagnosis, by quantity of service, by frequency of service, and by individual authorizer.
- Total service amounts billed in certain categories (such as home health) compared with the total number of services authorized for a combination of services.
- The number of authorized services provided and remaining, and IBNR supporting trend reports (e.g., run out averages by provider type, service type, target group).

4.6.13 Accept service authorizations that specify an effective time period for the authorization (e.g., services authorized for 6 months or one year).

4.6.14 Accept pre-authorizations or ISPs as input and generate standard pre-authorization notifications to providers based upon the ISP or pre-authorization data, as specified in individual agreements.

4.6.15 Accept self directed support eligibility and preauthorization data, to use to correctly identify self directed services in encounter reporting.

4.6.16 Accept pre-authorization data from third party service coordinators or recipients in self directed supports case situations.

4.6.17 Accommodate atypical claim forms used for self directed supports services authorizations and recipient approval or verification of services.

4.6.18 Provide claim review processes to verify recipient approval of services in self directed service situations. Accommodate global recipient approval of services by provider.

4.6.19 Perform mass updates of prior authorizations; for example, provide capability to globally change provider ID numbers or procedure codes or modifiers on active or pending prior authorizations.

4.6.20 Maintain detailed audit trail reports of all changes to prior authorization records.

4.6.21 Accept and respond to prior authorization status checks.

4.6.22 Maintain and provide access to the following data for amended prior authorizations:
- Amendment number.
- Amended services codes and descriptions.
- Amended authorized amounts (units, dollars).
- Amended date.
- Amended reason code and message.
- Amended reason message.
- Reviewer identification and authorizer identification.

4.6.23 Generate prior authorization reports including, but not limited to:
- Dollar value of services authorized.
- Suspended prior authorizations.
- Duplicate prior authorizations.
- Frequency of service codes requested and authorized.
- Utilization reports (including the number of times particular services were approved), by provider, provider type, recipient, individual types of services, and combinations of services.
- Denials (including denial reason), approvals, modifications, amendments, pends (including pend reason), with year-to-date (YTD) totals.
- Outstanding approved prior authorizations that have not been used within a specific time period.

4.6.24 Accept pre-authorizations with one or more provider type limitations (e.g., PhD, MSW, RN) and process claims against these pre-authorizations from any of the designated provider types.

Optional Contracting Functions

4.6.25 Notify the contracting organization if the specific dollar amount or units are reached and future claims will not be paid.

4.6.26 Accept standard ISP data to set up service pre-authorizations for self directed services.

4.6.27 Provide the capability to produce standard service authorizations to providers based on ISP or pre-authorizations provided by service coordinators or case managers.

4.7 Provider Management

Bulletin Level Setup

4.7.1 Establish a process to track sanctioned providers, accommodating date sensitivity and type of sanction. Obtain information from appropriate federal and state agencies (e.g., CMS, Federal and State Office of Inspector General, Department of Regulation and Licensing and others). Validate and report providers sanctioned at the state or federal level to the contracting organization and/or the DHS.

4.7.2 Establish a process to track and maintain long term care facility information including, but not limited to, the following:
- Number of beds (Medicaid and Medicare).
- Level of care.

4.7.3 If required, reconcile information from Medicare carriers and intermediaries or COB Medicare contractors when received and make necessary changes to the Medicare provider information within five (5) business days of receipt of information from the Medicare carriers and intermediaries.

Organization Level Contracting

4.7.4 Pend or deny claims based on contracting organization or DHS direction for various circumstances (e.g., claims without preauthorization may be pended for one organization to review while these may be denied for another organization).

PMPM

4.7.5 Maintain provider demographics including, but not limited to, NPI, contract effective dates, and client-specific rate information necessary to process claims.

4.7.6 Control the ability to apply retroactive changes to provider data. Provide limited override capability with automatic claims and authorization adjustments and/or reports in the event retroactive changes are made.

4.7.7 Monitor and apply reimbursement rates based on Medicare Fee Schedules, Medicaid Fee Schedules, or on contract specific (or recipient specific) rates.

4.7.8 Monitor and report the impact of provider file changes on existing authorizations.

4.7.9 Track provider status for special programs and allow other indicators. Program indicators that further identify the provider include program contract affiliation for each contracting organization (e.g., one MCO that contracts for both Family Care and Family Care Partnership programs).

4.7.10 Track and maintain provider status codes with their associated date spans. The status codes must include at a minimum:
- Closed or out of business.
- Change of ownership.
- Limited time-span status.
- Status pending.
- Terminated (voluntary or involuntary).
- Provider deceased.
- Provider retired.

4.7.11 Maintain non-medical or atypical provider records with standard demographic data and identify relationships to special programs.

4.7.12 Use state-defined standardized abbreviations for data fields in the provider file.

4.7.13 Provide the ability to allow multiple provider types and specialties for an individual provider, including the status for each type and specialty.

4.7.14 Accommodate provider specialty codes and provider type codes, numeric or alphabetic or a combination, according to HIPAA requirements.

4.7.15 Maintain links to cross reference provider numbers and names.

4.7.16 Terminate provider records that meet specific contracting organization criteria (e.g., limits for provider contract renewal).

4.7.17 Maintain the contracting organization provider file separately from other lines of business. Maintain the provider data without overlaying it as a result of changes to data received from other lines of business. Provide reports to the contracting

organization when new or different data is received, to determine whether changes should be applied to the contracting organization data.

4.7.18 Provide the ability to accommodate the organization's internal provider record information, and process claims for internally provided services accordingly.

4.7.19 Complete updates to provider data maintenance within five (5) business days after receipt unless otherwise directed by the contracting organization.

4.7.20 Verify the accuracy of all additions and updates to the provider master file within one (1) business day of entry.

4.7.21 Make corrections to errors discovered during the provider verification process on the same business day as identified.

4.7.22 Perform additions, updates, verification, and corrections to the provider master file within the same business day, when it is the last day prior to the claims processing cycle.

4.7.23 Check periodically, as specified by the contracting organization, for any error occurrences of duplicate provider numbers. Report the findings along with the actions taken to resolve the duplicate situation to the contracting organization within five (5) business days.

Optional Contracting Functions

4.7.24 Notify the contracting organization of contract terminations and upcoming renewals, as appropriate.

4.7.25 Allow providers the ability to maintain their own provider demographic information.

4.7.26 Provide a portal to allow providers to pick up pre-authorizations, as determined by contracting organization agreements regarding the generation of pre-authorizations.

4.8 Grievance and Appeals Process Management

PMPM

4.8.1 Track grievances and complaints in an established tracking system through referral to the contracting organization, and following resolution direction from the contracting organization.

4.8.2 Identify the type and priority of grievances and complaints (e.g. urgent, emergency, routine).

4.8.3 Generate periodic reports as specified by the contracting organization including, but not limited to:
- Case status.
- Grievance.
- Complaints.
- Appeals counts and information.

4.8.4 Process all formal grievances, complaints, and appeals (written and oral) according to the required schedule and contracting organization policy and

guidelines. Responsibilities for processing all grievances, complaints and appeals include, but are not limited to:

- Generation and distribution of confirmations acknowledging receipt of grievance or appeal.
- Interaction with designated contracting organization staff regarding grievances, complaints and appeals.
- Assurance that responses to requests for information and processing adhere to timelines specified by the contracting organization.
- Attendance at, or participation in, complaint and appeal review meetings, as requested.
- Documentation of all contacts regarding grievances and appeals including source, date, information requested, received, and sent.

4.8.5 Begin processing grievances and complaints within one (1) business day of receipt.

4.8.6 Provide a confirmation letter to the service provider confirming receipt of the grievance within five (5) business days of receipt.

4.8.7 Accommodate separate grievance and appeal processes by program.

4.8.8 Review and respond to recipient appeal letters as directed by the contracting organization.

4.9 Customer Service and Support Functions

Bulletin Level Setup

4.9.1 Provide a training plan that identifies activities leading up to, and including, the training of providers and user staff, at all levels, in the proper use of the system and functions performed under this contract. The plan should include a description of the training objectives, methods, schedule, and activities and include details on the feedback and evaluation mechanisms that will be used. Requirements also include:

- Description of training materials.
- Description of training facilities (e.g., use of screens).
- Training schedule.
- Plans for remedial training.
- Methodology to ensure continued training for staff changing positions, and new service providers.
- Ongoing evaluation using specified evaluations.

4.9.2 Provide user training and technical assistance at start-up and periodically for new users that focuses on business processes, use of the system, and is tailored to the staff position or user role (e.g., clerical users, manager).

4.9.3 Provide dedicated training and technical assistance to providers at start-up to facilitate transition, and to new providers as they are added to the provider network.

4.9.4 Use training materials for training staff that are appropriate to that type of training and delivery method. All materials should meet the following requirements:

- Facilitate updating.
- Be written in a procedural, step-by-step format.

- Have instructions for sequential functions follow the flow of actual activity.
- Present error messages for all fields incurring edits and the necessary steps to correct the errors.
- Contain illustrations of windows and screens with all data elements and fields identified.

4.9.5 Develop and conduct a training evaluation process and submit a summary of the results of that evaluation to the contracting organization.

Organization Level Contracting

4.9.6 Issue recipient mailings, as directed by the contracting organization.

PMPM

4.9.7 Provide training, as specified in training plans to users and service providers.

4.9.8 Produce individual recipient explanation of benefits upon request.

4.9.9 Assist contracting organization staff with research, resolution, and response to customer service calls and contacts.

4.9.10 Notify the contracting organization of all legislative or executive level and media contacts.

4.9.11 Provide access to a test system or testing resources to allow the contracting organization the ability to test changes to set up, access test results, conduct joint development of set-up test plans, and test changes made to contracting organization systems that feed TPA processes.

4.9.12 Provide a single contract representative for each organization's contract with authority to make decisions and establish service levels. Identify primary and secondary backup contact resources for functional area supports (e.g., provider record set up, claims processing, accounts receivable).

4.9.13 Provide resources with specialized skills to support contract specific set up and transition activities (e.g., provider record set up, history conversions).

Optional Contracting Functions

4.9.14 Produce and distribute recipient explanation of benefits in accordance with federal regulations to all, or a sample of, individual recipients using selection criteria defined by the contracting organization. Statements shall be clear and easy to read and in logical plain English or other languages, as directed by the contracting organization.

4.9.15 Provide call center and help desk services to providers and recipients, or a recipient's authorized representative, regarding claims status as well as assistance for vendor-supplied software or the vendor system use.

4.9.16 Provide a dedicated call center and help desk resource that is trained and knowledgeable in the program, the atypical provider needs, and the community based claims business to better respond to atypical provider inquiries.

4.9.17 Maintain a call and contact management tracking system used to manage inquiries from recipients, providers, legislators, attorneys, potential providers, and other stakeholders.

4.9.18 Track calls and contacts with basic identifying information. The information shall include at a minimum:
- Time and date of call or contact.
- Provider name and identification number.
- Caller name.
- Nature and details of the call or contact.
- Type of inquiry (e.g., phone, written, face to face, internet, email).
- Length of call (for a phone contact).
- Caller's county.
- Customer service correspondent name and identification number.
- Response given by customer service correspondent and the format in which the response was given (e.g., written, telephone, e-mail).
- Status of inquiry (e.g., closed, follow-up needed).
- Capacity for free form text of at least five hundred (500) characters to describe problems and resolutions.

4.9.19 Create extract files or reports that contain summary information on all calls and contacts received during a specified timeframe.

4.9.20 Provide the ability to refer and track calls and contacts to other contracting organization staff for follow-up. When the call or contact is referred, in addition to the basic identifying information, the referral shall include:
- Call or contact priority.
- Referral date.
- Resolution due date.
- Actual resolution date.
- Referral person.
- Name and/or identification number of the person resolving the call or contact.
- Description of the resolution.

4.9.21 Establish and maintain inquiry routing and escalation procedures, as specified by contracting organization agreement.

4.9.22 Implement and maintain provider and recipient services customer service lines with toll-free numbers.

4.9.23 Maintain sufficient provider customer service phone lines and customer service correspondent staff so that:
- At least ninety-five percent (95%) of all calls are answered within three (3) rings.
- No more than five percent (5%) of all answered calls are on hold for more than one (1) minute.
- Ninety-five percent (95%) of all phone calls do not encounter a busy condition.
- Less than 5 percent of all phone calls are abandoned or dropped.

4.9.24 The call and contact management system must be available ninety-nine percent (99%) of the time per day.

4.9.25 Calls and contacts needing further research or follow-up must be responded to within two (2) business days of initial contact. The caller must be given a final response or inform the caller/contact that further research is needed.

4.9.26 Research and respond to technical policy, procedure, and pricing questions from providers and recipients, or a recipient's authorized representative.

4.9.27 Respond to provider inquiries on claims status and payment information including, but not limited to:
- Adjudicated claims.
- Paid amount.
- Claim status.
- Denial reason.
- Requests for electronic claim status capability.

4.9.28 Maintain call statistics including but not limited to:
- Time and Date of call.
- Identifying information on call.
- Call category.
- Inquiry description.
- Response description.
- Busy.
- Dropped calls.
- Call wait time.
- Length of call.

4.9.29 Generate, at a minimum, the following types of daily, weekly, and monthly reports:
- Incoming calls and contacts answered.
- After hours calls and contacts.
- Cumulative calls and contacts answered.
- Total calls abandoned.
- Abandoned or lost rate percent.
- Average wait time.
- Average hold time in queue.
- Call topic.

4.9.30 Deliver cultural diversity training to call and contact management center correspondents.

4.10 Data Maintenance and Data Integrity

PMPM

4.10.1 The security of the claims processing system must minimally provide the following three types of controls to maintain data integrity. These controls shall be in place at all appropriate points of processing.
- Preventive Controls: controls designed to prevent errors and unauthorized events from occurring.
- Detective Controls: controls designed to identify errors and unauthorized transactions that have occurred in the system.
- Corrective Controls: controls to ensure that the problems identified by the detective controls are corrected.

4.10.2 Allow entry, storage of, and access to provider data. Effective begin and end dates for appropriate elements must be provided. Provider data includes but is not limited to:
- Provider Number.
- Provider Name.

- Provider type, specialty, and/or taxonomy.
- Status.
- Multiple addresses including mailing address, payment address, multiple practice location and prior authorization notice or other notice addresses. Address format must conform to postal regulations and allow a zip plus 4 digit code.
- County and locality information.
- Phone number(s).
- Contact person(s).
- Multiple fax numbers.
- Multiple e-mail addresses.
- National Provider Identifier (NPI).
- Drug Enforcement Agency (DEA) number.
- Social Security Number (SSN).
- Federal Employer Identification Number (FEIN).
- License number.
- Categories of services for which a provider is allowed to bill.
- Approved transactions under the Trading Partner Agreement.
- Provider billing, rendering, or non-billing provider number and/or NPI.

4.10.3 Participate in annual data integrity audits, as required by the DHS. Participate in state and federal systems audits, as required.

4.10.4 Identify providers with a unique provider number using the National Provider Identifier (NPI), or standards consistent with NPI, and HIPAA requirements. Unique identifier information should include, but is not limited to, all locations, provider types, specialties, authorizations, certifications, licensing for services, and all other appropriate information for that provider as a logical record linked to the unique provider number.

4.10.5 Track provider and recipient enrollment for special programs and allow other indicators as needed to identify program participation.

4.10.6 Edit and verify accuracy of all entered data for presence, format, validity and consistency with other data in the update transactions for all files that allow update transactions (e.g., prevent duplicate provider enrollment).

4.10.7 Maintain an audit trail on all update transactions, for all files that can be updated.

4.10.8 Generate reports on any occurrences of duplicate provider or recipient numbers.

4.10.9 Select and purge records according to a schedule specified by the contracting organization.

4.10.10 Ensure the master provider file, pre-authorization file and any other relevant data files have been updated prior to the claims processing cycle.

4.10.11 Support and maintain internal quality assurance (QA) processes to detect and correct problems in all functional areas, and support and maintain internal quality improvement (QI) processes to detect and prevent quality issues from occurring; use contracting organization reports as input to these processes.

4.10.12 Develop and maintain a quality assurance program that is:
- Implemented across all system and operational responsibilities.
- Meets industry standards and best practices (e.g., ISO, QMS, TQM).

4.10.13 Provide the capability to link and/or merge all recipient's data.

4.10.14 Provide a process for unlinking all eligibility and claims data associated with a recipient when it is discovered that a recipient's eligibility has been merged erroneously with another recipient, has been erroneously split out from the recipient, or the identification number has been erroneously assigned to another recipient.

4.11 Reporting

Bulletin Level Development

4.11.1 Generate required reports as defined by the DHS including, but not limited to:
- Incurred But Not Reported (IBNR).
- Outstanding liability, including from claims and authorizations.
- Obligations based on authorization data.
- Quality of transactions received.
- Authorization trend reports (e.g., recipient consumption, compliance by category of service, by case manager).
- Reports to accommodate estate recovery (e.g., claims and receivables history for deceased recipients).

4.11.2 Generate claims control reports by program including, but not limited to, the following:
- Invalid transactions.
- Daily control activity.
- Adjustments entered.
- Corrections not applied.
- Daily batch errors.
- Inventory and production reports.
- Daily management summary.
- Error analysis.
- Error summary.
- Aged inventory - location age.
- Aged inventory - system age.
- Returned and denied claims.

Organization Level Contracting

4.11.3 Generate additional reports with claims entry statistics for assessing claims processing performance compliance, as specified by the contracting organization.

4.11.4 Generate aging reports, as specified by the contracting organization, to provide the ability to monitor work in progress or unfinished work in all areas of TPA responsibility including, but not limited to:
- Claims.
- Service authorizations.
- Receivables.
- New recipient set up.
- Provider additions and changes.
- Grievances and appeals.

4.11.5 Generate additional aging reports as specified by the contracting organization including, but not limited to:
- ISPs.
- Customer services inquiries.

4.11.6 Generate claims exception reports, as specified by the contracting organization, including:
- Outliers.
- High dollars.
- High units.

4.11.7 Provide a performance dashboard, available to contracting organization staff, by line of business that includes, but is not limited to claims inventory, claims and customer service turn-around time, and quality statistics.

PMPM

4.11.8 Generate and submit recipient-specific data in an encounter data format specified by the DHS and according to any HIPAA deadlines, standards and requirements applicable to the contracting organization. The specifications and HIPAA deadlines, standards and requirements are identified in documents found on the DHS web site at: http://dhs.wisconsin.gov/ltcare/Encounter.

4.11.9 Accommodate the mandated requirements for encounter data reconciliation specified in the encounter reporting implementation guide, as required by contracting organization agreements. Encounter data reconciliation specifications are identified in documents found on the DHS web site at: http://dhs.wisconsin.gov/ltcare/Encounter.

4.11.10 Generate standard reports as defined by the contracting organization including, but not limited to:
- Open prior authorizations at any point in time.
- Active prior authorizations versus claims received and processed.
- Paid, denied, and adjusted claims.
- Claims trend and analysis reports (e.g., submission times vs. dates of service for run out; lag reports by category of service, provider type).
- Data entry time lag.
- Claims lag (from date received to date check is mailed).

4.11.11 Ensure that the system has the capability to track, assess, estimate, and report on:
- The effectiveness and savings of each edit and audit (including revisions and updates).
- The impact of each edit and audit (including revisions and updates) on providers (e.g., by individual provider, provider type, service type, place of service, claim type, type of claim submission, recipient type) and their subsequent billing patterns.

4.11.12 Provide a regularly scheduled transmission of claims data to the contracting organization that includes all information included in the encounter data submissions, as defined in individual agreements.

5.0 ADDITIONAL REQUIREMENTS FOR FAMILY CARE PARTNERSHIP

Requirements in section 5.0 are all related to PMPM costs, and are in addition to the PMPM listed in section 4.0.

5.1 Claims Processing

PMPM

5.1.1 Contract with a nationally recognized drug updating service to update drug prices weekly.

5.1.2 Maintain DRG files to use in pricing inpatient and outpatient hospital claims. Seven (7) years of data must be maintained. The DRG file will contain, at a minimum, elements such as:

- DRG code.
- English translation of code (DRG description).
- Add date.
- Begin date.
- End date.
- DRG weight (relative value).
- Outlier Days (low and high days).
- Audit trail.
- Average length of stay.

5.2 Eligibility and Enrollment Maintenance

PMPM

5.2.1 Accept multiple enrollment and termination dates for Medicare integrated program members:

- Medicare fee for service benefits are effective the first of the month in which eligibility is granted and terminate the end of the month, in which coverage is terminated.
- Medicare managed care integrated benefits are effective on the first day of the first full month in which eligibility is granted and terminate on the last day of the month in which coverage is terminated.
- Medicaid Partnership is effective on the day on which eligibility is granted and terminates on the day on which coverage is terminated.

5.2.2 Maintain a benefit and pricing structure for both the Medicare and Medicaid Partnership components of the integrated plan.

5.2.3 Calculate Partnership plan benefits in their entirety using an internal, integrated coordination of benefits process, without requiring the providers to resubmit claims and producing one final remittance advice reflecting the benefit calculations of both plans.

5.2.4 Calculate the benefit, assuming that Medicare is the primary insurer and Partnership is the secondary insurer. In cases where other insurance exists, standard COB primacy rules would be followed for benefit calculations, in

addition to the internal benefit calculations for the integrated Medicare/Partnership plan.

5.2.5 Produce a single service record that reflects these calculations in claims history (and/or encounter transactions) which does not inflate units, services charges or other claims data.

5.2.6 Process coordinated benefits based on multiple enrollment and termination dates:
- Coordinate benefits using standard COB rules for the time period between the effective date of the Partnership benefit and the first of the month in which Medicare managed care integrated benefits become effective.
- Coordinate benefits based on the internal COB requirements for the period of time from the first of the month in which Medicare integrated benefits become effective and the date that Medicaid Partnership benefits terminate.

5.2.7 Process Medicare managed care benefits from the date Medicaid Partnership ends through the end of the month in which Medicare managed care benefits terminate.

5.2.8 Process dental claims.

5.2.9 Provide and maintain current and historical DRG numbers, narrative descriptions, rates, weights, and effective dates to be used in claims processing and that supports accurate DRG assignment.

5.2.10 Recalculate payments resulting from post pay DRG validation reviews. The revised ICD coding used for DRG may be in either electronic or paper format. The appropriate DRG validation must be based on date of discharge.

5.2.11 Provide for inpatient hospital pricing methodologies including but not limited to:
- DRG grouping.
- DRG with outlier if an outlier is applicable.
- Per diem.
- Days eligible.
- Percentage of charge.
- Other methods specified by contracting organization agreements.

5.2.12 Apply all outpatient hospital pricing methodologies as well as the ability to bundle certain revenue codes into a flat rate per revenue code. Outpatient hospital pricing methodologies include but are not limited to:
- Rate per visit.
- Flat rate per revenue code.
- Rate per revenue code, service and procedure code, or billed amount (whichever is less).
- Procedure code, and diagnosis code.
- Percentage of charge per revenue code.

5.2.13 Conduct post pay DRG validation reviews.

5.3 Grievance and Appeals Process Management

PMPM

5.3.1 Accommodate independent grievance and appeals processes for Medicare and Medicaid, based on eligibility and/or the service identified in the grievance or appeal (e.g., the Medicare and Medicaid Partnership programs require different tracking and notifications, including remittance advice messages).

5.4 Reporting

PMPM

5.4.1 Produce risk adjustment data submissions for CMS, as directed by the MCO.

5.5 Pharmacy Benefit Management

PMPM

5.5.1 Maintain a minimum of twenty-four (24) months of online, real-time pharmacy claims history, including records of all claim payments, accounting, reporting, and drug rebate.

5.5.2 Develop necessary interfaces to assure the availability of accurate information regarding member eligibility, drug pricing information, provider eligibility, other insurance resources, member benefit limitations, managed care enrollment status, and other data necessary to process pharmacy claims.

5.5.3 Calculate payments applying various co-pay arrangements as defined or approved by the MCO.

5.5.4 Maintain the claim history, provider, recipient files and control reports for the MCO, based on state or federal requirements as appropriate.

5.5.5 Generate reports based upon selected pharmacy and physician criteria, such as:
- NDCs, generic drug codes, or therapeutic classification codes of drugs and specific diagnosis codes.
- NDCs, generic drug codes, or therapeutic classification codes and quantities of drugs prescribed by a specific physician or filled by a specific pharmacy.

5.5.6 Perform or subscribe to services for the following operational PBM responsibilities including but not limited to:
- Negotiating supplemental rebates.
- Maintaining preferred drug list.
- Reviewing and approving prior authorization requests and criteria.
- Providing customer service.
- Quality and patient safety.
- Formulary management and development.

5.5.7 Accept and process all retail pharmacy claims consistent with MCO policy.

5.5.8 Provide the ability to adjudicate drug claims based on Medicare Part D requirements.

5.5.9 Accept multiple National Drug Codes (NDCs) to support compound drug pricing.

5.5.10 Apply different dispensing fees to drug claims based on MCO criteria.

5.5.11 Track and provide reports to compare actual acquisition cost and usual and customary charge information to billed charges on drug claims.

5.5.12 Perform POS editing of pharmacy claims to identify non-covered drugs based on a table of state approved Generic Code Numbers (GCN), and/or NDCs, or NDC ranges not covered by specified benefit plans; notify the provider through an online, real-time response when a drug is not covered.

5.5.13 Provide POS edits for drugs requiring prior authorization.

5.5.14 Edit POS claims for a valid prescriber number.

5.5.15 Support POS managed care editing for inclusion or exclusion of pharmacy services.

5.5.16 Price POS pharmacy claims consistent with state reimbursement rules in accordance to MCO policy including, but not limited to:
- The ingredient Maximum Allowable Cost (MAC).
- Estimated Acquisition Cost (EAC).
- Average Wholesale Price (AWP).
- Appropriate dispensing fees.
- Pharmaceutical care.
- Compound drugs.

5.5.17 The processing requirements for Prospective DUR include identification and monitoring drug usage for FFS claims including but not limited to:
- Over utilization.
- Under utilization.
- Therapeutic duplication.
- Drug and/or disease contraindication.
- Drug and/or drug interaction.
- Incorrect drug dosage.
- Incorrect duration of drug treatment.

5.5.18 Generate the following Prospective DUR reports including but not limited to:
- Summarization report of the severity and the number of alerts that have occurred over a given period. Based upon the results of this report, specific reports to display additional detail for any given type or category of alert may be requested by the State. Listings of all drug claims and diagnostic information per member and the amount of money involved.
- User-defined period of time (e.g., all DUR activity that occurred for a date range).
- Dispensing statistics for prescription filled from the preferred drug list.
- Alerts and/or denials by types, quantity, and by prescribing provider and pharmaceutical provider.

5.5.19 Validate DEA information prior to update. Automate the reconciliation of data accuracy between the DEA subscription information and the provider data. Automatically correct invalid information. Validate and report discrepancies periodically to the MCO, as specified by the MCO agreement.

5.5.20 Provide expertise to negotiate best prices and rebates.

6.0 ADDITIONAL REQUIREMENTS FOR CHILDREN'S AND OTHER WAIVERS

Requirements in section 6.0 are all related to PMPM costs, and are in addition to the PMPM listed in section 4.0.

6.1 Claims Processing

PMPM

6.1.1 Accept local service coding values on waiver claims for community-based non-medical services throughout a pre-defined transition period.

6.1.2 Provide the flexibility to calculate, issue, and report claims payments or hold claims payments in accordance with individual county waiver agency agreements.

6.2 Eligibility and Enrollment Maintenance

PMPM

6.2.1 Accommodate user defined enrollment termination reasons by program.

6.2.2 Accommodate the termination of benefits based on various age limitations or service maximums, over-riding pre-authorization data.

6.3 Service Authorization Management

PMPM

6.3.1 Capture specific information on waiver claims based upon pre-authorization service types.

6.3.2 Provide the ability to over-ride authorizations for intensive services when they exceed the program limit, even when the services are pre-authorized.

6.4 Reporting

PMPM

6.4.1 Develop reports for intensive service costs by participant within specified date range (requires data collection regarding county of financial responsibility, begin and end dates of intensive service period, dates of service, and service codes for intensive services).

7.0 COST PROPOSAL

7.1 General instructions on preparing cost proposals

The cost proposal should be submitted in a separate envelope, and must accompany the written proposal. The proposal will be scored using a standard quantitative calculation where the most points will be awarded to the proposal with the lowest cost. Various costing methodologies and models are available to analyze the cost information submitted to determine the lowest costs to the State. The State will select one method and use it consistently throughout its analysis.

7.2 Format for submitting cost proposals

The Cost Proposal Form in Appendix B references five (5) areas of pricing for the requirements of this RFP. Please note; all costs submitted are for evaluation purposes.

The Cost Proposal Form must be signed by a person authorized to commit the proposing entity to a legal and binding contract.

Proposed cost items will be scored on a scale, relative to the costs submitted by the other proposers. Cost proposals will include:

- Bulletin Level Development; statewide, bulletin level, development for standard input and output development. This is expected to be a flat fee for development.
- Bulletin Level Set up; statewide, bulletin level, set up for standardized configuration. A level of set up will be standardized for all contracting organizations. This includes program logic, set up, and configuration as well as one time set up for training and system documentation. This is expected to be a flat fee for set up. Set up for children's waiver programs will be standardized at the Department level.
- Organization Level Contracting; organization level set-up costs for an additional level of set up that is expected for customization to each contracting organizations' individual business operations. This includes technical assistance to both providers and contracting organizations for transition; training and documentation; and specific customization of workflow, edits, and outputs. Children's waiver programs will not require individual customization of workflow, edits, training and documentation other than that specified at the bulletin level. Set up activities for Family Care and Family Care Partnership are expected one time per MCO or other contracting agency, and are expected to be completed within six months. The cost for this category of activities is expected to be an hourly cost. Time and expenses will not exceed current state vendor limits.
- Per Member, Per Month (PMPM); a standardized set of core business requirements included in the PMPM, which will reflect the true cost to provide the operational services of the TPA and include the pre-defined functions specified in the RFP requirements sections (4.0, 5.0, and 6.0). This includes ongoing maintenance of set up and customization specified in the three (3) cost categories listed above. Licensing fees for TPA software or third party software use are also expected to be included in the PMPM, and other claims processing overhead expenses. Core PMPM costs are expected to be tied to monthly

claims volume in vendor-defined volume ranges, and volume-based discounts should be reflected on the cost proposal form. Any additional PMPM costs for requirements in sections 5.0 and 6.0 must be reported separately, as specified on the cost proposal form.

- Optional Contracting Functions; a standardized set of optional services, which includes ad hoc reporting for MCOs and other contracting organizations. This is expected to be a flat fee.

In addition to the categories of costs listed above, the cost proposal must identify any anticipated increases or discounts (e.g., volume pricing, pricing of electronic vs. paper volume).

It is the responsibility of the vendor to process claims in accordance with federal and state statutes. In the event that claims are not handled in a timely manner and statutory interest is due, the interest is the liability of the vendor, and will not be passed on to the claims payer.

Additionally, it is the responsibility of the vendor to cover the cost of any clearing house functions.

8.0 SPECIAL CONTRACT TERMS AND CONDITIONS

8.1 DHS contract criteria

In the event of contract award, the master agreement will incorporate the contents of this RFP (including all attachments), RFP addenda and revisions, State responses to vendor questions, the proposal of the successful proposer, and additional terms agreed to, in writing, by the agency and the contractor shall become part of the contract. Failure of the successful proposer to accept these as a contractual agreement may result in a cancellation of award.

Standard Terms and Conditions (DOA-3054) and Supplemental Standard Terms and Conditions for Procurements for Services (DOA-3681) are provided in Appendices C and D, respectively. Failure of the successful proposer to accept these obligations in a contractual agreement may result in cancellation of the award.

The State of Wisconsin requires the prime contractor to assume responsibility for contract performance when subcontractors are used. When subcontractors are used, they must abide by all terms and conditions of the contract. All business requirements apply to proposed sub-contracting of functions.

The State of Wisconsin is committed to the promotion of minority business in the state's purchasing program and a goal of placing 5% of its total purchasing dollars with certified minority businesses. Authority for this program is found in ss. 15.107(2), 16.75(4), 16.75(5) and 560.036(2), Wisconsin Statutes. The contracting agency is committed to the promotion of minority business in the state's purchasing program.

The State of Wisconsin policy provides that minority-owned business enterprises certified by the Wisconsin Department of Commerce, Bureau of Minority Business Development should have the maximum opportunity to participate in the performance of its contracts. The supplier/contractor is strongly urged to use due diligence to further this policy by awarding subcontracts to minority-owned business enterprises or by using such enterprises to provide goods and services incidental to this agreement, with a goal of awarding at least 5% of the contract price to such enterprises.

The supplier/contractor shall furnish appropriate quarterly information about its effort to achieve this goal, including the identities of such enterprises certified by the Wisconsin Department of Commerce and their contract amount.

A listing of certified minority businesses, as well as the services and commodities they provide, is available from the Department of Administration, Office of the Minority Business Program, (608) 267-7806. The listing is published on the Internet at: http://commerce.wi.gov/BD/BD-MBD-Index.html.

8.2 Additional contract criteria

In addition to the DHS master agreement, MCOs, county waiver agencies, and other contracting organizations may each have their own contract terms and conditions that must be negotiated and incorporated into any contract negotiated with the selected vendor(s). Failure of the successful proposer to accept these as a contractual agreement may result in a cancellation of award. Agencies and organizations will define the specific services to be delivered and any necessary operational specifications to be incorporated into each contract.

DHS will require prior review and approval of all contracts before being signed and executed.

Examples of special terms and conditions that may be included in individual contracts include, but are not limited to:

- **Payment requirements**; contracting organizations may choose to tie payments to the delivery of specific products in their contracts.
- **Liquidated damages**; contracting organizations may require the contractor to compensate them for failures to perform or to meet set performance expectations and liquidate such damages through deduction from the contractor's invoices or by direct billing to the contractor.
- **Penalties**; contracting organizations may choose to stipulate performance expectations in their contracts, and may reserve the right to impose fees for nonperformance. Contracting organizations may additionally choose to specify financial responsibilities related to omissions and errors made by the TPA.
- **Contract termination notification**; contracting organizations may specify additional conditions for termination of their contracts.

APPENDIX A; PROPOSAL RESPONSE TEMPLATE

Proposed solutions to meet each requirement in sections 4.0, 5.0, and 6.0 must be complete and fully describe functions and processes related to the requirements.

- Responses should include, but are not limited to, policies, procedures, methodologies, resources, qualifications, availability, and/or timelines associated with the proposed solution, as applicable.
- References to previous responses are acceptable, as long as full, complete, and clearly identified responses are provided for each requirement.
- Responses to each requirement must clearly indicate whether the proposed system currently accommodates each requirement without modification or requires minor or significant system modification to meet the requirement.
- If modifications are required, the proposer must specify the timeframe required to fully meet the requirement (from the time of contract).

CORE BUSINESS SYSTEM REQUIREMENTS FOR ALL PROGRAMS

Administration

4.1.1	Provide 24 x 7 access to all contract-related documents maintained by the TPA.
Response:	
Require Modification?	
4.1.2	Provide systems support to the contracting organization during extended work hours (e.g., 6:00 a.m. to 6:00 p.m., Monday through Friday).
Response:	
Require Modification?	

4.1.3	Maintain electronic images of all claims-related service documents and provide for remote retrieval of these images including, but not limited to: - Claims. - Service authorizations. - Receivables. - New recipient set up. - Provider additions and changes.
Response:	
Require Modification?	
4.1.4	Comply with HIPAA, ADA, and other federal and state regulations, and perform in accordance with contract terms and conditions.
Response:	
Require Modification?	
4.1.5	Ensure electronic data transfers comply with HIPAA transaction format requirements, as applicable.
Response:	
Require Modification?	
4.1.6	Ensure all functions operate in accordance with the HIPAA final and amended rules for security and privacy.
Response:	
Require Modification?	
4.1.7	Conform to all state and federal confidentiality laws, and ensure that HIPAA data security, and privacy standards are met. Establish safeguards to protect the integrity and confidentiality of all data to assure information is not released without proper consent of the recipient. Track all releases of recipient personal data according to HIPAA privacy requirements.
Response:	

Require Modification?	
4.1.8	Provide a flexible solution to effectively meet the requirements of upcoming HIPAA regulations and other national standards development. The system must accommodate changes with global impacts (e.g., implementation of ICD-10-CM diagnosis and procedure codes, eHR, e-Prescribe) as well as new transactions (e.g., ASC X12N 275: Additional Information to Support a Healthcare Claim) at no additional cost.
Response:	
Require Modification?	
4.1.9	Provide a system that meets all requirements of currently issued National Provider Identifier (NPI) regulation.
Response:	
Require Modification?	
4.1.10	Accept and process or generate the following HIPAA mandated batch and real-time transactions, other versions or standards that may be mandated and other transactions including, but not limited to: - Health care claims (professional, institutional). - Eligibility for a health plan. - Health care services review - request for review and response. - Health care claim status request and response. - Benefit enrollment and maintenance. - Health care claim payment/advice. - Payroll deducted and other group premium payment for insurance products. - Coordination of benefits for health care claims (professional, institutional). - Functional acknowledgements.
Response:	
Require Modification?	
4.1.11	Comply with all HIPAA transaction implementation guides.
Response:	

Require Modification?	
4.1.12	Develop and use internal quality control procedures to monitor operations, data entry, and accuracy of processing for all functional areas.
Response:	
Require Modification?	
4.1.13	Maintain cross-reference indexing of documents using recipient and provider identification numbers, as appropriate.
Response:	
Require Modification?	
4.1.14	Establish and manage a user group for contracting organizations.
Response:	
Require Modification?	
4.1.15	Participate in the DHS code committee and comply with decisions made by the committee; describe the qualifications of staff available for participation.
Response:	
Require Modification?	
4.1.16	Participate in the DHS IT Workgroup, QA/QI workgroups, and any other DHS workgroups as requested by either the DHS or the contracting organization; describe the qualifications of staff available for participation in the IT and QA/QI workgroups.
Response:	
Require Modification?	

4.1.17	Submit a business continuity plan that addresses, at a minimum, the following: - Business continuity planning team, including a description of the organization, roles, and responsibilities. - Criteria for executing the business continuity plan, including escalation procedures. - Communication plan for critical personnel, key stakeholders and business partners. - Business functions and dependent functions that must be maintained and services that must be restored, including key business information that would be required within 24 to 48 hours of a declared disaster or event. - Recovery time for each major business function, based on priority. - Business workflow and workaround procedures, including alternate processing methods and performance metrics. - Recording and updating business events information, files, data updates, once business processes have been restored. - Security procedures for protection of data. - Ensure back-up copies are stored in a secure off-site location, and tests are routinely performed on back-up copies.
Response:	
Require Modification?	
4.1.18	Submit a disaster recovery plan that includes, at a minimum, the following: - Adequate back-up and recovery system in compliance with federal and state rules and regulations. - Communication plan for critical personnel, key stakeholders and business partners. - Periodic back-up which is adequate and secure for all computer software and operating programs; databases; files; and system, operations, and user documentation (e.g., electronic, non-electronic, incremental, full). - Full and complete back-up copies of all data and software. - Ensure back-up copies are stored in a secure off-site location, and tests are routinely performed on back-up copies. - Policy and procedures for purging outdated backup data. - Support the immediate restoration and recovery of lost or corrupted data or software resulting from the event of a disaster. - Provide for a back-up processing capability at a remote site(s) from the primary site(s) such that normal payment processing and services can continue in the event of a disaster or major hardware problem at the primary site(s).
Response:	
Require Modification?	

4.1.19	Provide sufficient transaction logging and data backup to allow the system(s) to be restored to any point in time. Restoration must ensure that all data are synchronized to prevent data corruption.
Response:	
Require Modification?	
4.1.20	Maintain electronic images of all contract-specified service documents and provide for remote retrieval of these images including, but not limited to: - ISPs and case files. - Grievances and appeals. - Customer services inquiries.
Response:	
Require Modification?	

Claims Processing

4.2.1	Accommodate claims submissions for atypical services from atypical providers through the use of a standard format and web based submission, designed for these types of community-based service providers. Indicate whether these claims for atypical services are, or can be, derived from pre-authorizations.
Response:	
Require Modification?	
4.2.2	Accommodate provider remittance advice for atypical services from atypical providers through the use of a standard format and web based application, designed for these types of community-based service providers.
Response:	
Require Modification?	
4.2.3	Allow the submittal of decimal units and calculate payment based on the decimal versus rounding to a whole unit, as required by contracting organizations, and as directed by DHS policy.
Response:	

Require Modification?	
4.2.4	Link subsequent submitted claims to denied claims when possible.
Response:	
Require Modification?	
4.2.5	Periodically assess the fiscal impact of accepting Medicare crossover claims with the DHS and the contracting organization to agree upon the cost benefit of implementing the service or discontinuing the service. (Include frequency of assessments in your response.)
Response:	
Require Modification?	
4.2.6	Implement restrictions on conditions to be met for a claim to be paid within the benefit packages including, but not limited to: - Provider type. - Provider specialty. - Category of service (SPC). - Recipient age. - Recipient sex. - Place of service. - Procedure codes - Modifiers. - Diagnosis codes.
Response:	
Require Modification?	
4.2.7	Implement DHS or contract specified restrictions on conditions to be met for a claim to be paid within the benefit packages (which include multiple waiver programs), including the ability to vary claim resolution actions (e.g., pay, pend, deny) by line of business and by error type.
Response:	

Require Modification?	
4.2.8	Place edit and/or audit criteria limits on types of service by procedure code, by revenue code, by diagnosis code, by drug class, or based on specified data elements (e.g., recipient information, provider type and specialty, time periods, units, cost).
Response:	
Require Modification?	
4.2.9	Implement restrictions on conditions to be met for a claim to be paid within the benefit packages based on contracting organization agreements including, but not limited to: - Accident-related and insurance-related indicators for coordination of benefits. - Required attachment indicators. - Prior authorization indicators and effective date(s). - DME limitations (i.e., life expectancy). - Medicare Part A-covered service and effective date(s). - Medicare Part B-covered service and effective date(s). - Co-pay indicator and effective date(s).
Response:	
Require Modification?	
4.2.10	Deduct either the provider reported or recipient liability amounts from claims, track remaining balances, and provide the capability to invoice recipients for the remaining monthly amount due, as directed by the contracting organization. Maintain the service charge data for encounter reporting.
Response:	
Require Modification?	
4.2.11	Accept and deduct patient liability amounts from claim records and provide the ability to apply patient payment amounts, as directed by the contracting organization. Maintain the service charge data for encounter reporting.
Response:	

Require Modification?	
4.2.12	Establish a security policy and implement procedures that ensure the safety and confidentiality of all data transmissions between the contracting organization and the TPA.
Response:	
Require Modification?	
4.2.13	Maintain reference data that supports claims edits, audits, and pricing logic in accordance with DHS and contracting organization policies. The application of these policies is subject to change; therefore, the edits, audits, and pricing methodologies described in this RFP shall not be considered an exhaustive list.
Response:	
Require Modification?	
4.2.14	Maintain and update HIPAA mandated code sets, approved versions of HCPCS procedure codes, ICD-9-CM diagnosis and procedure codes, CDT procedure codes, revenue codes, Diagnostic Related Groups (DRG), and NDC drug codes.
Response:	
Require Modification?	
4.2.15	Obtain regularly scheduled updates for HCPCS and CPT from CMS and AMA.
Response:	
Require Modification?	
4.2.16	Maintain current and historical reference data, assuring that updates do not overlay or otherwise make historical information inaccessible.
Response:	
Require	

Modification?	
4.2.17	Maintain a procedure file which contains five (5) character HCPCS, CDT, and CPT codes for medical-surgical, dental, and other professional services; two (2) character HCPCS and CPT modifiers; ICD-9-CM surgical, obstetrical, and miscellaneous diagnostic and therapeutic procedure codes; eleven (11) digit NDCs; four (4) digit revenue codes; and CDT dental codes. The procedure file will contain, by program, at a minimum, elements such as: - Maximum procedure code history with a minimum of seven (7) years of status (active, inactive) code segments with effective begin and end dates for each segment. - Coding values that indicate if a procedure is covered by Medicare, Medicaid, and/or other programs. - Numerous parameters used in claims processing including, but not limited to: provider type, specialty, sub-specialty, recipient age and/or gender restrictions, place of service, modifier, co-pay indicator, eligibility aid category, emergency indicator, claim type, diagnosis, units of service, review indicator, and tooth number or letter. - Multiple modifiers with different pricing factors applicable to each modifier. - Two (2) digit place of service code. - Procedures manually priced or reviewed. - Information such as accident-related indicators for possible TPL, federal cost-sharing indicators, Medicare coverage, and allowed amounts.
Response:	
Require Modification?	
4.2.18	The procedure code file must contain parameters used in claims processing including, but not limited to, provider type, specialty, recipient age and gender restrictions, place of service, modifier, claim type, diagnosis, units of service, and dates of service.
Response:	
Require Modification?	
4.2.19	Maintain procedure code relationships to ensure claims for related procedures are not unbundled or coded differently (e.g., the same service submitted with a revenue code and a HCPCS code) and paid on the same day for the same individual.
Response:	
Require	

Modification?	
4.2.20	Maintain revenue code files with a data set that contains, but is not limited to: - Maximum revenue code history with a minimum of seven (7) years after the end date of status code segments with effective begin and end dates for each segment. - Numerous parameters used in claims processing including but not limited to: provider type, specialty, sub-specialty, recipient age and/or gender restrictions, claim type, diagnosis, units of service, and review indicator. - Information such as accident-related indicators for possible TPL, federal cost-sharing indicators, Medicare coverage, and allowed amounts.
Response:	
Require Modification?	
4.2.21	Maintain a drug file using the NDC, which can accommodate regular, periodic updates from a contracted drug pricing service, as specified by contracting organizations.
Response:	
Require Modification?	

4.2.22	Maintain a diagnosis file of medical diagnosis codes utilizing the three (3), four (4), and five (5) character ICD-9-CM coding system, which can maintain relationship edits for each diagnosis code, including: - Age. - Gender. - Begin date. - End date. - Add date. - Audit trail. - Place of service. - Prior authorization. - Inpatient length of stay criteria. - Emergency indicator. - Trauma indicator. - Description of the diagnosis. - Accident indicator. - DRG Medicare code. - Sterilization indicator. - Family planning status. - Primary and secondary diagnosis code usage. - Review indicator. - Indicators associated with selected parameters to designate whether they should be included, excluded or disregarded in claims and/or encounter processing.
Response:	
Require Modification?	
4.2.23	Maintain separate tables by program to assign state-defined SPC codes to encounter transactions.
Response:	
Require Modification?	
4.2.24	Define and enforce the use of appropriate procedure coding schemes (e.g., HCPCS, ICD-9-CM, CDT) and/or diagnosis coding schemes (e.g., ICD-9-CM) based on parameters such as claim type, provider type and specialty, place of service, or service rendered.

Response:	
Require Modification?	
4.2.25	Establish processes, or subscribe to services, that evaluate claims submissions for the need to enhance the unbundling and other data relationship protocols.
Response:	
Require Modification?	
4.2.26	Maintain positive and negative data relationships. The types of relationships shall include, but are not limited to, procedure to provider types and specialties, procedure-to-procedure, procedure to diagnosis, procedure to recipient age, and procedure to recipient gender.
Response:	
Require Modification?	
4.2.27	Maintain current and historical recipient and provider names and their assigned identification numbers. Provide an automated link to claims for the recipient and provider under current and historical names and identification numbers.
Response:	
Require Modification?	
4.2.28	Incorporate audit trails to allow information on all transactions to be traced through all processing stages with the ability to trace data from the final place of recording back to its source.
Response:	
Require Modification?	
4.2.29	Process third party coverage updates received from certifying agencies, providers, and as a result of errors in processing insurance company file matches. (Include frequency of updates in your response.)
Response:	

Require Modification?	
4.2.30	Maintain all third party resource information at the recipient-specific level including, but not limited to: - Carrier name and identifier. - Policy number and group number. - Effective date of coverage and end date of coverage, if applicable. - Add date, change date and verification date of insurance. - Source of the insurance information identifier. - Type of verification of insurance identifier. - Policy holder name, address, SSN, date of birth, relationship to insured, employer name and address. - Specific information on types of services covered by the policy, as defined by the contracting organization. - Part A and/or Part B Medicare. - Medicare Managed Care plan. - Medicare Supplemental plan. - Drug Plan. - Tricare.
Response:	
Require Modification?	
4.2.31	Maintain a file of all carriers during the life of the contract that includes, but is not limited to: - Carrier name and identifier. - Technical contact name and phone number. - Corporate contact name, address and telephone number. - Claims submission address and phone number. - Indicators of coverage by defined categories of services as applicable. - Active or inactive status.
Response:	
Require Modification?	
4.2.32	Maintain all third party resource information at the recipient-specific level including, but not limited to, names, identifiers, unlimited number of other insurance plans, policy and group numbers, coverage dates, sources, services, and payers. Provide third party coverage investigation services, based on injury-related diagnoses, and conduct

	regular queries to proactively update recipients' other insurance information.
Response:	
Require Modification?	
4.2.33	Maintain a minimum of twenty-four (24) months of online claims history, including records of all claim determinations, accounting, and reporting.
Response:	
Require Modification?	
4.2.34	Accept COB information from the DHS, MCOs, county waiver agencies, other contracting organizations, and other private, state, and federal sources, and process third party coverage information from all sources according to defined criteria.
Response:	
Require Modification?	
4.2.35	Coordinate benefits with other insurance benefits including, but not limited to: - Subrogation. - Worker's Compensation. - Medicare. - Medicaid. - Private health, long-term care, casualty, or liability.
Response:	
Require Modification?	
4.2.36	Maintain multiple third party coverage information for individual recipients for all periods of eligibility.
Response:	
Require Modification?	

4.2.37	For each edit and/or audit exception, provide all resolution information including, but not limited to, a resolution code; an override, force or deny indicator; and the date the error was resolved, forced, or denied, and by whom. All claims must carry sufficient information to provide a complete online audit trail of all exception processing. These data elements shall be maintained in the claims history to support provider and claims processing audits.
Response:	
Require Modification?	
4.2.38	Maintain program specific claim filing time limits and enforce them in the claims processing edit processes. Calculate claims processing time from valid claim receipt date. Claim filing time limit may vary by program and may be over-ridden by the decision of the contracting organization.
Response:	
Require Modification?	
4.2.39	Support and maintain a cross reference file that connects standard codes, rates, and COB information used by the long term care, waiver, and other DHS programs for pre-authorizations, claims processing, encounter reporting, research, and analysis, and benefit packages.
Response:	
Require Modification?	
4.2.40	Receive claims in a variety of mediums including, but not limited to, HIPAA-compliant electronic formats and paper documents from providers, billing services, contracting organizations, Medicare carriers and intermediaries, and coordination of benefits contractors.
Response:	
Require Modification?	
4.2.41	Process electronic claim transactions, tapes, and discs within one (1) business day of receipt.
Response:	
Require	

Modification?	
4.2.42	Identify, upon receipt, each claim record and adjustment with an ICN that designates the origin of claim record, year and date of receipt. Attachments should carry the ICN of the relevant claim record with a suffix or other indicator identifying it as an attachment.
Response:	
Require Modification?	
4.2.43	Accept paper and HIPAA-compliant electronic attachments and link to the original claim using the ICN. Attachments should carry the ICN of the claim record with a suffix or other indicator identifying it as an attachment.
Response:	
Require Modification?	
4.2.44	Assign an ICN to every claim, transaction, attachment, and adjustment and optically store (scan) every claim, attachment, and adjustment within one (1) business day of receipt at the contractor site. This includes controlling documents without sufficient information to index.
Response:	
Require Modification?	
4.2.45	Deny or reject all electronic claims transactions that do not comply with HIPAA mandated standards, with the exception of agreed upon transactions for atypical claims.
Response:	
Require Modification?	

4.2.46	Accept additional claim inputs, including but not limited to: - Claims for Medicare coinsurance and deductible (crossover claims), in both paper and electronic formats. - Attachments required for claims adjudication, including coordination of benefits and Medicare explanation of medical benefits. - Non-claim specific financial transactions such as fraud and abuse settlements, insurance recoveries, and cash receipts. - Subrogation. - Worker's Compensation. - Reinsurance payments.
Response:	
Require Modification?	
4.2.47	Establish controls to ensure that no paper claims and attachments, tapes, discs, or other data are misplaced, lost, or duplicated after receipt.
Response:	
Require Modification?	
4.2.48	Edit all required data elements for presence and validity on all entered claims, according to DHS specifications, as directed by the contracting organization.
Response:	
Require Modification?	
4.2.49	Process claims according to defined benefit packages and pre-authorization requirements.
Response:	
Require Modification?	
4.2.50	Maintain benefit package information, including program coverage requirements, edits and audits, and provide data (or access to data) for analysis.
Response:	

Require Modification?	
4.2.51	Maintain identifiers and taxonomy for provider types and specialties participating in various benefit packages including atypical and non-licensed, but program-approved, service providers.
Response:	
Require Modification?	
4.2.52	Maintain information on benefit package coverage including, but not limited to, recipients; providers; programs; place of service; procedure, modifier, and diagnosis codes; services authorized under each benefit package; and services included or excluded for each benefit package.
Response:	
Require Modification?	
4.2.53	Maintain system capability and flexibility to accurately accommodate benefit package changes within time frames specified or approved by the contracting organization.
Response:	
Require Modification?	
4.2.54	Support the administration of a variety of benefit packages and claims processing and program administration requirements.
Response:	
Require Modification?	
4.2.55	Track claims and other documents that are returned to the provider or other source including, but not limited to, the date returned, and the reason for the return.
Response:	
Require	

Modification?	
4.2.56	Edit to ensure all required attachments are present.
Response:	
Require Modification?	
4.2.57	Pend or deny claims for specified time frames when no matching attachments (e.g., activity reports, follow-up reports) are provided.
Response:	
Require Modification?	
4.2.58	Perform adjudication of claims, including special or atypical claims, using edits, audits, and processing rules in accordance with specified guidelines (e.g., deny, override). Describe categories of edits and/or audits available.
Response:	
Require Modification?	
4.2.59	Systematically accept global changes to suspended claims, based on defined criteria, and release claims for editing.
Response:	
Require Modification?	
4.2.60	Edit to ensure other insurance benefits have been satisfied and maximized, and a valid insurance denial attachment is present when it is required.
Response:	
Require Modification?	
4.2.61	Edit for recipient eligibility and enrollment on date(s) of service.
Response:	

Require Modification?	
4.2.62	Edit for valid billing, attending, rendering, referring, and/or prescribing provider number or NPI, as appropriate.
Response:	
Require Modification?	
4.2.63	Edit for prior authorization requirements, and verify the claim services match an active prior authorization for those services, independent of the pre-authorization identification number.
Response:	
Require Modification?	
4.2.64	Edit to assure the claim is from an authorized provider. Generate notifications when a non-authorized provider is submitting a claim.
Response:	
Require Modification?	
4.2.65	Edit prior authorized claims and reduce billed units, dollars, or days' supply, based on authorization limits and the recipient's historical consumption of services.
Response:	
Require Modification?	
4.2.66	Calculate and recoup payments made for services that exceed the original authorized units, dollars, and/or services.
Response:	
Require Modification?	
4.2.67	Perform automated crosschecks and relationship edits and audits on all claims.

Response:	
Require Modification?	
4.2.68	Perform logical claims sequencing of edits and audits.
Response:	
Require Modification?	
4.2.69	Perform automated audit processing using history claims, suspended claims, in-process claims, and same cycle claims.
Response:	
Require Modification?	
4.2.70	Follow-up with carriers on a schedule specified by the contracting organization when insurance coverage is not present on the recipient file but a TPL payment is shown on the claim. Update other insurance records as appropriate, and notify the contracting organization of any changes to other insurance coverage information.
Response:	
Require Modification?	
4.2.71	Edit and/or audit for potential and exact duplicate claims, including cross-references between group and rendering providers; multiple provider locations; and across provider types and categories of service.
Response:	
Require Modification?	
4.2.72	Identify and track all edits and audits posted to the claim in the entire processing cycle. Provide reports to allow the analysis of edit and audit impact on claims in various categories.
Response:	
Require	

Modification?	
4.2.73	Maintain an audit trail for each claim record that shows each stage of processing, the date the claim entered each stage, and any edit and/or audit codes posted to the claim at each step in processing.
Response:	
Require Modification?	
4.2.74	Calculate the allowed claims payment amount according to date specific pricing and Medicare and Medicaid approved reimbursement methodologies.
Response:	
Require Modification?	
4.2.75	Identify potential and existing COB opportunities, including Medicare, and deny the claim when it is for a covered service under another insurance resource, for applicable claim types (e.g., an atypical chore service would not be denied where other health insurance exists).
Response:	
Require Modification?	
4.2.76	Maintain a record of the related benefit package for each claim.
Response:	
Require Modification?	
4.2.77	Maintain the original billed amount, calculated allowed amount, any manually priced amount, and the actual payment amount on the claim history record.
Response:	
Require Modification?	
4.2.78	Return claims to providers that do not meet approved screening criteria.

Response:	
Require Modification?	
4.2.79	Establish claims control balancing processes.
Response:	
Require Modification?	
4.2.80	Identify and monitor operators who are authorized to force or override an edit and/or audit based on individual operator identification and/or authorization level.
Response:	
Require Modification?	
4.2.81	Perform claims reconciliation between claim receipts and batch processing input.
Response:	
Require Modification?	
4.2.82	Retain paper documents and claims until the document image quality has been verified, the batch is fully adjudicated, and the retention schedule has lapsed.
Response:	
Require Modification?	
4.2.83	Assure that Medicare crossover claim and adjustment media types are uniquely identified on all standard claim statistic reports.
Response:	
Require Modification?	

4.2.84	Identify and develop recommendations regarding policy and/or adjudication guidelines that are unclear and/or cause problems in adjudicating claims.
Response:	
Require Modification?	
4.2.85	Maintain claims that have been purged from active claims history indefinitely on a permanent history archive with key elements of the history claim.
Response:	
Require Modification?	
4.2.86	Identify and advise the contracting organization of proposed changes to edits and audits to enhance processing and efficiency.
Response:	
Require Modification?	
4.2.87	Process individual, mass, and gross adjustments submitted as HIPAA-compliant electronic transactions and as paper transactions.
Response:	
Require Modification?	
4.2.88	Provide a flexible mass or individual adjustment process that can be controlled by various parameters or selection criteria (e.g., procedure code, provider ID) for all claims.
Response:	
Require Modification?	
4.2.89	Conduct retrospective review and identify and recover payments for claims processing errors.
Response:	

Require Modification?	
4.2.90	Perform adjustments to original and adjusted claims and maintain records of all previous processing. Perform all claim adjustment activities according to GAAP. (See the encounter reporting implementation guide found on the DHS web site at: http://dhs.wisconsin.gov/ltcare/Encounter for details on making adjustments.)
Response:	
Require Modification?	
4.2.91	Prevent multiple adjustments to a single claim record. (See the encounter reporting implementation guide found on the DHS web site at: http://dhs.wisconsin.gov/ltcare/Encounter for details on making adjustments.)
Response:	
Require Modification?	
4.2.92	Suspend and adjust provider claims in the normal claims processing sequence, so that facilities providers can receive partial payment for payable lines and only resubmit suspended portions in the next cycle.
Response:	
Require Modification?	
4.2.93	Update provider payment history and recipient claims history with all appropriate financial records and reflect adjustments in subsequent reporting, including claim specific and non-claim specific recoveries. Refund non-claim specific financial payments and recoveries, as defined by individual agreement.
Response:	
Require Modification?	
4.2.94	Generate adjustment reports according to specifications, as defined by individual agreement.
Response:	
Require	

Modification?	
4.2.95	Designate to which fiscal year adjustments and other financial transactions are to be reported. Accommodate cut-off requirements for fiscal reporting, as specified.
Response:	
Require Modification?	
4.2.96	Maintain all claim history (original claims and all previous adjustments) with all of the original information including, but not limited to, the original paid amount, the adjusted amount, the full amount gross calculated, and the net amount calculated.
Response:	
Require Modification?	
4.2.97	Identify all claim records affected by retroactive rate adjustments, create adjustment records for them, reprocess them, and maintain a link between the original and adjusted claim.
Response:	
Require Modification?	
4.2.98	Re-edit, re-price, and re-audit each adjustment, including checking for duplication against other regular and adjustment claim records, in history and in process.
Response:	
Require Modification?	

4.2.99	Identify and calculate payment amounts according to established rules and rates. Accommodate these and any future pricing methods: - Rate on file or billed amount, whichever is less. - Percentage of rate on file. - Anesthesia Pricing using a formula. - DRG pricing. - Procedure code modifier pricing. - Manual pricing. - Nursing home daily rate. - Nursing home prospective payment system. - Resource Utilization Groups (RUGs) - Long Term Acute Care Hospital (LTACH) - Facility specific per diem rate. - Outpatient hospital rate per visit (day). - Outpatient prospective payment system. - Crossover claim pricing, including Part B pricing reductions. - Incentive payment pricing. - MAC, EAC, or AWP minus a percentage for drugs plus dispensing fee per prescription. These are prescription pricing methodologies. - Individual waiver program pricing methodologies.
Response:	
Require Modification?	
4.2.100	As needed, apply all of the above mechanisms according to: - Geographic area by county or ZIP code of provider or recipient. - Individual provider number. - Provider number. - Individual recipient identification number. - Recipient age, gender, or aid category. - Provider type or specialty.
Response:	
Require Modification?	

4.2.101	Adjust benefits and service limitations (e.g., prior authorization) based on claims adjustments and modify pre-authorization amounts available, as appropriate.
Response:	
Require Modification?	
4.2.102	Ensure suspended or pended claims are re-edited based on pre-authorizations and other claims edit criteria in effect for the dates of service or processing dates, as appropriate.
Response:	
Require Modification?	
4.2.103	Provide reports of the ICNs of claims selected for mass adjustments online to determine the impact of the adjustment prior to the actual adjustment process.
Response:	
Require Modification?	
4.2.104	Enter claim adjustment transactions received on paper documents.
Response:	
Require Modification?	
4.2.105	Accommodate date sensitivity editing with iterations of data for all maintained data fields.
Response:	
Require Modification?	
4.2.106	Provide the capability for providers to receive the remittance advice on paper, electronically, or both.
Response:	
Require	

Modification?	
4.2.107	Generate and display approved information messages on the banner page of the paper remittance advice.
Response:	
Require Modification?	
4.2.108	Generate a remittance advice, even if the payment amount is zero.
Response:	
Require Modification?	
4.2.109	Generate a simplified provider remittance advice for atypical providers that reflects data specific to atypical services.
Response:	
Require Modification?	
4.2.110	Provide the ability to collect the contracting organization's internally provided case management services data (e.g., case management) for reporting purposes but suppress payments for these services.
Response:	
Require Modification?	
4.2.111	Meet all paper claims and adjustment processing standards set by the state or the federal government. These standards include processing claims as follows: - Ninety percent (90%) of all claims shall be processed within ten (10) calendar days of receipt. - Ninety-five percent (95%) of all claims shall be processed within twenty-one (21) calendar days of receipt. - Ninety-nine percent (99%) of all claims shall be processed within thirty (30) calendar days of receipt. - One hundred percent (100%) of all claims shall be processed within ninety (90) calendar days of receipt.
Response:	
Require Modification?	

4.2.112	Maintain the contracting organization's provider remittance advice process separately from other lines of business, as specified in individual agreements.
Response:	
Require Modification?	
4.2.113	Meet all electronic claims and adjustment processing standards set by the state or the federal government. These standards include processing claims as follows: - Ninety percent (90%) of all claims shall be processed within five (5) calendar days of receipt. - Ninety-five percent (95%) of all claims shall be processed within ten (10) calendar days of receipt. - Ninety-nine percent (99%) of all claims shall be processed within fifteen (15) calendar days of receipt. - One hundred percent (100%) of all claims shall be processed within twenty (20) calendar days of receipt.
Response:	
Require Modification?	
4.2.114	Accept contracted rate information from the contracting organization. Price provider claims using provider specific and program specific contracted rates for recipients. Also, price based on individual pre-authorization negotiated rates, as required by the contracting organization, or based on Medicaid rates.
Response:	
Require Modification?	
4.2.115	Maintain multiple nursing facility (long-term care) rates, per provider.
Response:	
Require Modification?	

4.2.116	Accept rates for services including, but not limited to: - Individual. - Pre-authorization. - Provider. - County. - Program.
Response:	
Require Modification?	
4.2.117	Maintain pricing data based on: - Fee schedules by benefit package. - Provider-specific usual and customary charges. - Procedure modifiers (e.g., DME). - Per diem rates. - Self-directed support services by budget or dollar limit. - DRGs. - Multiple-level dispensing fee for drugs (e.g., compound, enhanced, repackaging allowance). - MAC, EAC, AWP, AWP- ten percent (10%), and direct pricing for drugs. - Case-mix rates for LTC (in addition to facility-specific per diem rates by level of care).
Response:	
Require Modification?	
4.2.118	Provide the ability to compare rates between waiver and Medicaid services in order to pay at the most cost-effective rate, as directed by the contracting organization.
Response:	
Require Modification?	
4.2.119	Generate expenditure, eligibility and utilization data to support budget forecasts, monitoring and health care program modeling.
Response:	

Require Modification?	
4.2.120	Accommodate retroactive changes, future changes, and expanded pricing processes with no additional cost.
Response:	
Require Modification?	
4.2.121	Continue claims processing services for 180 days after termination date for dates of service prior to the termination date at no additional cost. During and at the end of the termination run-out period, the contractor will fully cooperate in the transfer of all records and reports, including computer records and other data as requested by contracting organization within 10 business days of the request, at no additional cost.
Response:	
Require Modification?	
4.2.122	Receive and process regularly scheduled files from insurance companies to identify and update recipient records based upon third party payer information.
Response:	
Require Modification?	
4.2.123	Receive and process Worker's Compensation information on a periodic basis, as determined by the contracting organization.
Response:	
Require Modification?	
4.2.124	Identify and advise the DHS and the contracting organization of code set changes including proposed edit and audit changes.
Response:	
Require	

Modification?	
4.2.125	Provide access for research purposes to a cross reference between local codes, state codes, and national codes used for claims adjudication.
Response:	
Require Modification?	
4.2.126	Accept historical claims data from other vendors (e.g., cost share, claims run in for take-over cases). Provide the ability to accept and process take-over claims inventory and transition responsibility of that inventory.
Response:	
Require Modification?	
4.2.127	Provide the contracting organization with the ability to submit claims on behalf of providers, if requested.
Response:	
Require Modification?	
4.2.128	Provide the contracting organization with the flexibility to review claims that the TPA intends to return to the provider for more information.
Response:	
Require Modification?	
4.2.129	Pend claims and notify the contracting organization of unauthorized services as specified by service agreements.
Response:	
Require Modification?	
4.2.130	Accommodate atypical coordination of benefit requirements based on contracting organization or program agreements (e.g., pay and pursue for other insurance, subrogation or workers' compensation).

Response:	
Require Modification?	
4.2.131	Interface with Medicare contractors to exchange eligibility information, and other data as specified by the DHS or the contracting organization, to use in matching information for Medicare crossover claims, if applicable.
Response:	
Require Modification?	
4.2.132	Report to the contracting organization any problems related to receipt of automatic crossovers and adjustments (e.g., electronic crossovers received directly from the Medicare intermediary or carrier) that impact the timely processing of claims.
Response:	
Require Modification?	
4.2.133	Schedule meetings with the contracting organization and Medicare contractors when necessary to resolve issues related to receipt or processing of Medicare crossover claims.
Response:	
Require Modification?	
4.2.134	Accommodate the claim history reconciliation of provider pre-payments by tracking pre-paid amounts as receivables, adjusting claims history as service claims are presented and reflecting the adjustments through the EOB process. The processes need to maintain the integrity of the financial posting process.
Response:	
Require Modification?	
4.2.135	Provide the flexibility to establish payment time frames by provider, within the performance standards.
Response:	

Require Modification?	

Fraud and Abuse Oversight

4.3.1	Develop contracting organization defined reports to support audit programs that include the recipients being audited, the services being audited, and the date range of services for any given recipient.
Response:	
Require Modification?	
4.3.2	Perform data matches to identify potential fraud and abuse occurrences, as defined by the contracting organization.
Response:	
Require Modification?	
4.3.3	Track complaints and referrals from outside parties and agencies regarding recipients or providers. Track dispute resolutions.
Response:	
Require Modification?	
4.3.4	Provide an automated fraud and abuse profiling system for the ongoing monitoring of provider and recipient claims to detect patterns of potential fraud, abuse, and excessive billing. The system must be able to perform targeted or intensive monitoring of specific providers, services, procedures, diagnoses, and/or recipients over time. Monitoring includes, but is not limited to: - Bundling and unbundling. - Medically unnecessary services. - Overuse of services for all claims, provider types, and recipient categories. - Medically unnecessary care. - Fraud and abuse by providers. - Fraud and abuse by recipients. - Fraud and abuse by TPA, contracting organization, and any other contracted employees. - Inappropriate billing practices.

	- Clinically inappropriate or unnecessary utilization compared to nationally recognized practice parameters.
Response:	
Require Modification?	
4.3.5	Profile, track, and analyze paid claims data to identify the following: - Potential fraud and abuse by providers, recipients, and employees. - Inappropriate and excessive billings and over payments, including unethical billing practices, upcoding, unbundling, and other creative billing practices, and violations of provider instructions conveyed via applicable Medicare, Medicaid, and contracting organization handbooks and bulletins. - Access, quality, use, and cost of all Medicare and/or Medicaid covered health care services and key utilization management issues.
Response:	
Require Modification?	
4.3.6	Identify cases with the highest potential for fraud and/or abuse.
Response:	
Require Modification?	
4.3.7	Perform provider billing pattern analysis of illogical or inappropriate billing across any health care setting.
Response:	
Require Modification?	
4.3.8	Generate a regularly scheduled report on potential fraud and abuse activities, as defined by individual agreement.
Response:	
Require Modification?	
4.3.9	Represent the contracting organization as necessary and provide testimony for findings from investigations that are

	appealed and/or for which hearings or trials are conducted.
Response:	
Require Modification?	
4.3.10	Provide operations support for audit programs. The audit support must include for review, at a minimum, claim information; payment, partial payment, and recoupment information; potential duplicate claims information; eligibility and enrollment information; and other insurance information.
Response:	
Require Modification?	
4.3.11	Provide various contracting organization defined reports to support audit programs, both prior to and after the audit.
Response:	
Require Modification?	
4.3.12	Generate regular, periodic audit status reports based on specifications defined by the contracting organization.
Response:	
Require Modification?	
4.3.13	Notify the contracting organization when potential fraud is suspected or when it is reported by a recipient, as appropriate.
Response:	
Require Modification?	

General Accounts Payable, Receivable, and Cash Receipting Functions

4.4.1	Customize the process of pending or withholding payments on adjudicated claims and transactions according to contracting organization policies, procedures and/or requests, and provide authorized users with access to pended transaction data by claim type, media, payee type and identification number, program area, amount, fund code, and

	category of service (e.g., when a provider receives payment from both the contracting organization and an insurance carrier, and when provider does not respond in a timely manner).
Response:	
Require Modification?	
4.4.2	Customize the release of pended claims and/or transactions manually or automatically, as specified by individual contracting organization agreement and by provider agreement. Provide the ability to: - Manually release pended claims and/or transactions. - Automatically recycle pended claims and/or transactions. - Control the timing of the release of pended claims and/or transactions.
Response:	
Require Modification?	
4.4.3	Provide the ability to offset a provider payment to recoup receivables due from that provider, at the recipient service level, as specified in contracting organization agreements. Provide notification to the provider that a refund is due prior to the offset.
Response:	
Require Modification?	
4.4.4	Establish and monitor a system for generating payments according to state and federal guidelines, both automatically (system generated) or manually, using EFT or manual distribution as appropriate.
Response:	
Require Modification?	
4.4.5	Run required cycles of automated payment and refund processing on schedules approved by the contracting organization.
Response:	
Require	

Modification?	
4.4.6	Maintain authorized payment and refund processing cycles.
Response:	
Require Modification?	
4.4.7	Maintain an authorized system for voiding, stopping, replacing, stale dating and reissuing payments and refunds, and establish agreed upon communication protocols for requesting voids, stop payments, and reissues.
Response:	
Require Modification?	
4.4.8	Void, stop payment, adjust, replace and reissue payments and refunds, as stipulated by contracting organization policies, procedures and requests.
Response:	
Require Modification?	
4.4.9	Establish and maintain a process for generating check registers at the end of each designated payment cycle.
Response:	
Require Modification?	
4.4.10	Establish and maintain security for printed checks and check stock during the storage, print and mailing processes in accordance with GAAP.
Response:	
Require Modification?	
4.4.11	Maintain an audit trail of all updates to accounts payable transactions.
Response:	

Require Modification?	
4.4.12	Establish and maintain internal auditing procedures and cycles in accordance with GAAP.
Response:	
Require Modification?	
4.4.13	Establish security and internal control measures for maintaining the confidentiality of the information contained in the accounts payable and receivable systems.
Response:	
Require Modification?	
4.4.14	Maintain electronic (EFT) payment and refund transaction information.
Response:	
Require Modification?	
4.4.15	Establish and reconcile a bank master file for documenting all payments and refunds issued and their current status. Establish a claims receivable process to tie out and balance claims receivables to claims history adjustments. Provide inventory and aging reports for un-reconciled receivables.
Response:	
Require Modification?	
4.4.16	Establish and maintain a process for producing and submitting accounts payable reports and payment summaries.
Response:	
Require Modification?	
4.4.17	Meet all industry and U.S. Postal Service standards regarding electronic fund transfers (EFT) and paper check distribution.

Response:	
Require Modification?	
4.4.18	Withhold provider payments based on state or federal levy requests.
Response:	
Require Modification?	
4.4.19	Establish and maintain separate bank accounts for multiple programs at an approved bank.
Response:	
Require Modification?	
4.4.20	Suppress the processing of zero-payment checks without suppressing the associated remittance advice within the accounts payable system, and create a report of zero-payments for each payment cycle.
Response:	
Require Modification?	
4.4.21	Maintain a system for tracking payer transactions received (e.g. the refund of an overpayment), making adjustments to the account receivables accordingly, and making appropriate adjustments to service pre-authorization records.
Response:	
Require Modification?	
4.4.22	Maintain a system that tracks accounts receivable data and pended amounts. The summary level data shall consist of calendar week-to-date, month-to-date, year-to-date, and the state and federal fiscal year-to-date totals.
Response:	
Require Modification?	

4.4.23	Monitor status of outstanding accounts receivables and generate letters for outstanding accounts receivables.
Response:	
Require Modification?	
4.4.24	Pend accounts receivable collections for bankruptcies and deaths. Generate reports for Medicaid estate recovery as defined by the DHS.
Response:	
Require Modification?	
4.4.25	Collect appropriate accounts receivables based on bankruptcy court resolution.
Response:	
Require Modification?	
4.4.26	Establish and maintain a recoupment process that includes supporting documentation for instances of overpayments, incorrect payments or payments to ineligible payers.
Response:	
Require Modification?	
4.4.27	Maintain multiple receivable accounts by payer.
Response:	
Require Modification?	
4.4.28	Provide the ability to accept receivables from a single provider and split and apply to multiple payers accounts.
Response:	
Require Modification?	

4.4.29	Establish and maintain security and internal control measures for maintaining the confidentiality of the information contained in the accounts receivable system.
Response:	
Require Modification?	
4.4.30	Provide the ability to link post payment recovery to the original claim.
Response:	
Require Modification?	
4.4.31	Accept and process HIPAA-compliant electronic remittance advice from payers for posting payments received.
Response:	
Require Modification?	
4.4.32	Operate and manage the accounts receivable functions in compliance with GAAP.
Response:	
Require Modification?	
4.4.33	Perform accounts receivable functions to include, but not limited to: - Collection of overpayments. - Maintenance of payments due as the result of audits and peer review findings. - Reconciliation of claims receivables to claims history adjustments. - Adjustment of benefit or pre-authorization records to reflect any refunds of previously decremented service authorizations.
Response:	
Require Modification?	

4.4.34	At minimum, process financial transactions including, but not limited to: - Accounts receivables. - Recoupments. - Manual checks. - Application of checks received to accounts receivable. - Application of checks to a payer's payment history file. - Check stop payment and EFT reversals. - Check voids and void re-issue and EFT reversals.
Response:	
Require Modification?	
4.4.35	Establish and maintain financial processing and adjustment processing policies and procedures and posting instructions.
Response:	
Require Modification?	
4.4.36	Issue initial and follow-up letters regarding claims-related receivables according to DHS guidelines, in accordance with individual contracting organization agreements.
Response:	
Require Modification?	
4.4.37	Produce payer payment reports after each payment processing cycle.
Response:	
Require Modification?	
4.4.38	Designate financial status of all cash receipt transactions including, but not limited to, record creation, documentation, and maintenance.
Response:	

Require Modification?	
4.4.39	Update financial claims history to reflect cash receipts.
Response:	
Require Modification?	
4.4.40	Generate cash receipt reports and maintain supporting documentation.
Response:	
Require Modification?	
4.4.41	Identify and track all cash receipts by type and/or source.
Response:	
Require Modification?	
4.4.42	Deposit all cash receipts by type and/or source within 48 hours.
Response:	
Require Modification?	
4.4.43	Provide accounting processes for non-claim specific financial transactions (e.g., member share payment collection transactions) including, but not limited to: - Application of collections received to cash receipts and satisfaction of accounts receivable. - Application of refunds received to a payer's payment history file, with reconciliation processes to assure all receipts are credited to the historical records. - Institutional liability amounts owed by recipients. - Date of service, date of adjudication, date of payment.
Response:	
Require	

Modification?	
4.4.44	Provide secure banking and financial information procedures.
Response:	
Require Modification?	
4.4.45	Track and maintain all information required for generating the annual 1099 income report.
Response:	
Require Modification?	
4.4.46	Generate post payment bills to be sent to Medicare, intermediaries, and insurance companies in formats specified by the contracting organization. This includes HIPAA-approved formats, including NCPDP, CMS-1500, and UB-04 claim forms.
Response:	
Require Modification?	
4.4.47	Perform accounts receivable functions to include, but not limited to: - Collection of member share including cost share, room and board, spend down, and voluntary contributions; and parental payment limit. - Tracking spend down limits by recipient. - Coordination of member share amounts paid to multiple sources.
Response:	
Require Modification?	
4.4.48	Create invoices and notices, including recipient cost share, according to schedules defined by the contracting organization.
Response:	
Require	

Modification?	
4.4.49	Collect member share payments, apply the payments, monitor the process and report to the contracting organization on the collections at a payer and summary level, maintain collection payment transaction information. At a minimum, the cost sharing function must: - Accept and process cost sharing information from the DHS or the contracting organization. - Reduce provider payments as appropriate based on members'/participants' cost sharing information, or reflect cost sharing in claims history transactions.
Response:	
Require Modification?	
4.4.50	Maintain a collection process for cost share, room and board, voluntary contributions, parental payment limit, and spend down payments to the contracting organization, as directed by the contracting organization. Receive and process collection payments including, but not limited to, the following types: - Checks. - EFT transactions. - Money orders. - Cash.
Response:	
Require Modification?	

Eligibility and Enrollment Maintenance

4.5.1	Receive eligibility information in a variety of mediums including, but not limited to, HIPAA-compliant electronic formats, and paper documents.
Response:	
Require Modification?	

4.5.2	Maintain recipient data to support processing of long term care claims including, but not limited to: - Level of Care. - Level of Care effective dates. - Spend down amount. - Recipient location data. - Case management unit. - County of residence. - Specific office locations within a county. - County of fiscal responsibility.
Response:	
Require Modification?	
4.5.3	Accept HIPAA compliant eligibility/enrollment information from the DHS, contracting organization, and/or CMS as directed by individual agreements.
Response:	
Require Modification?	
4.5.4	Provide controls to prevent retroactive adjustments to eligibility and/or enrollment dates. Provide limited override capability with automatic claims and authorization adjustments and/or reports in the event retroactive changes are made.
Response:	
Require Modification?	
4.5.5	Maintain recipient eligibility status including enrollments and disenrollments, including dates and reasons. There may be multiple entries for one recipient.
Response:	
Require Modification?	
4.5.6	Produce reports on enrollments and disenrollments, as specified by the contracting organization.

Response:	
Require Modification?	
4.5.7	Accept and process claims based enrollment dates that occur on the date of eligibility rather than the first of the month.
Response:	
Require Modification?	
4.5.8	Provide enrollment reports calculating enrollment days for programs which enroll on the eligibility date, versus the first of the month.
Response:	
Require Modification?	
4.5.9	Accommodate the capture of county of fiscal responsibility as an enrollment data element, which may change over the course of a program enrollment period.
Response:	
Require Modification?	
4.5.10	Create and maintain a unique recipient identification number for each recipient with capability to store identification numbers that are up to fourteen (14) characters in history, as directed by the contracting organization agreements.
Response:	
Require Modification?	
4.5.11	Maintain current and historical recipient names and assigned identification numbers, and provide an automated link to claims for the recipient under current and historical names and identification numbers.
Response:	
Require	

Modification?	
4.5.12	Support regular, periodic enrollment reconciliation activities by the contracting organization, as specified in individual agreements.
Response:	
Require Modification?	
4.5.13	Accept recipient eligibility and provide secure update capability to designated contracting organization staff.
Response:	
Require Modification?	
4.5.14	Provide the ability to issue ID cards and enrollment information packets to members/participants including the ability to reflect multiple eligibility dates for Medicare integrated program members, tracking multiple identification numbers accordingly.
Response:	
Require Modification?	

Service Authorization Management

4.6.1	Accept service prior authorizations and amendments by paper, fax, telephone, or electronic transmissions in the appropriate HIPAA-compliant manner.
Response:	
Require Modification?	

4.6.2	Capture, and provide access to, prior authorization data which includes, at minimum, the following: - Prior authorization number. - Recipient information. - Service Information, including: requested start date, rendering provider number, coding information, modifiers, place of service, description of service, quantity authorized, quantity used, dollar amount charged, begin and expiration date. - Receive date. - Date approved. - Expiration date. - History of all actions taken, including amendments. - Date of last change, ID of person changing, and information changed. - Review date. - Date adjudication notice sent to provider and recipient. - Authorizing person identification. - Free-form text area for special considerations, along with a flag to allow identification of authorizations with special considerations. - A text area which will be printed on the prior authorization notice, using predefined messages as well as unique messages (e.g., informing providers of cases where the original code requested was changed to reflect the diagnosis on the authorization).
Response:	
Require Modification?	
4.6.3	Provide regular reports of all changes made to prior authorization data to the contracting organization including, but not limited to, date of change, ID of person making the change, and the specific information that has been changed.
Response:	
Require Modification?	
4.6.4	Provide the ability to match claims to specific pre-authorized services (not just to a pre-authorization identification number), matching and decrementing pre-authorizations based on provider encounter specific data.
Response:	
Require	

Modification?	
4.6.5	Implement and maintain an automated process to link hard copy prior authorization attachments, such as x-rays and dental models, with the corresponding electronic prior authorizations.
Response:	
Require Modification?	
4.6.6	Update prior authorization records based on claims processed to indicate that the authorized service has been used or partially used, including units and dollars, during each prior authorization request period. This includes the restoration of authorized units based on claims adjustments.
Response:	
Require Modification?	
4.6.7	Process prior authorizations for non-covered services according to guidelines defined by the contracting organization. For example, in some cases a contracting organization may decide to allow specified service circumstances (e.g., type and dollar threshold) without a prior authorization.
Response:	
Require Modification?	
4.6.8	Edit prior authorizations for the presence of required data to include, but not limited to, the following: - Valid provider ID and eligibility. - Valid recipient ID and eligibility. - Valid procedure and diagnosis codes. - Presence of required claim type-specific data on the prior authorization. - Covered service. - Duplicate authorization check to previously authorized or previously adjudicated services (including denials) and duplicate requests in process. - Valid referring or prescribing provider, if required.
Response:	
Require	

Modification?	
4.6.9	Identify errors on prior authorizations with edits and/or audits that specify the field in error, suspend prior authorizations containing errors, and notify the contracting organization of the prior authorization suspense status. Notify the contracting organization with results of prior authorization clerical and/or clinical reviews and request additional information that is required from the contracting organization.
Response:	
Require Modification?	
4.6.10	Automatically close prior authorization records after a specified time period.
Response:	
Require Modification?	
4.6.11	Maintain provider-specific prior authorization history.
Response:	
Require Modification?	
4.6.12	Provide the capability for the contracting organization staff to analyze and report, at minimum, the following: - Claims applied against a prior authorization. - Prior authorization records and amendments meeting specified criteria. - Twenty-four (24) months online prior authorization history and/or other services whose approval period exceeds that period. - Prior authorization, expenditure, and service patterns of billing and rendering providers. - Prior authorization and adjudication characteristics and results, by provider type, by recipient type, by place of service, type of service, by named provider or recipient, by diagnosis, by quantity of service, by frequency of service, and by individual authorizer. - Total service amounts billed in certain categories (such as home health) compared with the total number of services authorized for a combination of services. - The number of authorized services provided and remaining, and IBNR supporting trend reports (e.g., run out averages by provider type, service type, target group).
Response:	

Require Modification?	
4.6.13	Accept service authorizations that specify an effective time period for the authorization (e.g., services authorized for 6 months or one year).
Response:	
Require Modification?	
4.6.14	Accept pre-authorizations or ISPs as input and generate standard pre-authorization notifications to providers based upon the ISP or pre-authorization data, as specified in individual agreements.
Response:	
Require Modification?	
4.6.15	Accept self directed support eligibility and preauthorization data, to use to correctly identify self directed services in encounter reporting.
Response:	
Require Modification?	
4.6.16	Accept pre-authorization data from third party service coordinators or recipients in self directed supports case situations.
Response:	
Require Modification?	
4.6.17	Accommodate atypical claim forms used for self directed supports services authorizations and recipient approval or verification of services.
Response:	
Require Modification?	

4.6.18	Provide claim review processes to verify recipient approval of services in self directed service situations. Accommodate global recipient approval of services by provider.
Response:	
Require Modification?	
4.6.19	Perform mass updates of prior authorizations; for example, provide capability to globally change provider ID numbers or procedure codes or modifiers on active or pending prior authorizations.
Response:	
Require Modification?	
4.6.20	Maintain detailed audit trail reports of all changes to prior authorization records.
Response:	
Require Modification?	
4.6.21	Accept and respond to prior authorization status checks.
Response:	
Require Modification?	
4.6.22	Maintain and provide access to the following data for amended prior authorizations: - Amendment number. - Amended services codes and descriptions. - Amended authorized amounts (units, dollars). - Amended date. - Amended reason code and message. - Amended reason message. - Reviewer identification and authorizer identification.
Response:	
Require	

Modification?	
4.6.23	Generate prior authorization reports including, but not limited to: - Dollar value of services authorized. - Suspended prior authorizations. - Duplicate prior authorizations. - Frequency of service codes requested and authorized. - Utilization reports (including the number of times particular services were approved), by provider, provider type, recipient, individual types of services, and combinations of services. - Denials (including denial reason), approvals, modifications, amendments, pends (including pend reason), with year-to-date (YTD) totals. - Outstanding approved prior authorizations that have not been used within a specific time period.
Response:	
Require Modification?	
4.6.24	Accept pre-authorizations with one or more provider type limitations (e.g., PhD, MSW, RN) and process claims against these pre-authorizations from any of the designated provider types.
Response:	
Require Modification?	
4.6.25	Notify the contracting organization if the specific dollar amount or units are reached and future claims will not be paid.
Response:	
Require Modification?	
4.6.26	Accept standard ISP data to set up service pre-authorizations for self directed services.
Response:	
Require Modification?	
4.6.27	Provide the capability to produce standard service authorizations to providers based on ISP or pre-authorizations

	provided by service coordinators or case managers.
Response:	
Require Modification?	

Provider Management

4.7.1	Establish a process to track sanctioned providers, accommodating date sensitivity and type of sanction. Obtain information from appropriate federal and state agencies (e.g., CMS, Federal and State Office of Inspector General, Department of Regulation and Licensing and others). Validate and report providers sanctioned at the state or federal level to the contracting organization and/or the DHS.
Response:	
Require Modification?	
4.7.2	Establish a process to track and maintain long term care facility information including, but not limited to, the following: - Number of beds (Medicaid and Medicare). - Level of care.
Response:	
Require Modification?	
4.7.3	If required, reconcile information from Medicare carriers and intermediaries or COB Medicare contractors when received and make necessary changes to the Medicare provider information within five (5) business days of receipt of information from the Medicare carriers and intermediaries.
Response:	
Require Modification?	
4.7.4	Pend or deny claims based on contracting organization or DHS direction for various circumstances (e.g., claims without preauthorization may be pended for one organization to review while these may be denied for another organization).

Response:	
Require Modification?	
4.7.5	Maintain provider demographics including, but not limited to, NPI, contract effective dates, and client-specific rate information necessary to process claims.
Response:	
Require Modification?	
4.7.6	Control the ability to apply retroactive changes to provider data. Provide limited override capability with automatic claims and authorization adjustments and/or reports in the event retroactive changes are made.
Response:	
Require Modification?	
4.7.7	Monitor and apply reimbursement rates based on Medicare Fee Schedules, Medicaid Fee Schedules, or on contract specific (or recipient specific) rates.
Response:	
Require Modification?	
4.7.8	Monitor and report the impact of provider file changes on existing authorizations.
Response:	
Require Modification?	
4.7.9	Track provider status for special programs and allow other indicators. Program indicators that further identify the provider include program contract affiliation for each contracting organization (e.g., one MCO that contracts for both Family Care and Family Care Partnership programs).
Response:	
Require	

Modification?	
4.7.10	Track and maintain provider status codes with their associated date spans. The status codes must include at a minimum: - Closed or out of business. - Change of ownership. - Limited time-span status. - Status pending. - Terminated (voluntary or involuntary). - Provider deceased. - Provider retired.
Response:	
Require Modification?	
4.7.11	Maintain non-medical or atypical provider records with standard demographic data and identify relationships to special programs.
Response:	
Require Modification?	
4.7.12	Use state-defined standardized abbreviations for data fields in the provider file.
Response:	
Require Modification?	
4.7.13	Provide the ability to allow multiple provider types and specialties for an individual provider, including the status for each type and specialty.
Response:	
Require Modification?	
4.7.14	Accommodate provider specialty codes and provider type codes, numeric or alphabetic or a combination, according to HIPAA requirements.

Response:	
Require Modification?	
4.7.15	Maintain links to cross reference provider numbers and names.
Response:	
Require Modification?	
4.7.16	Terminate provider records that meet specific contracting organization criteria (e.g., limits for provider contract renewal).
Response:	
Require Modification?	
4.7.17	Maintain the contracting organization provider file separately from other lines of business. Maintain the provider data without overlaying it as a result of changes to data received from other lines of business. Provide reports to the contracting organization when new or different data is received, to determine whether changes should be applied to the contracting organization data.
Response:	
Require Modification?	
4.7.18	Provide the ability to accommodate the organization's internal provider record information, and process claims for internally provided services accordingly.
Response:	
Require Modification?	
4.7.19	Complete updates to provider data maintenance within five (5) business days after receipt unless otherwise directed by the contracting organization.
Response:	

Require Modification?	
4.7.20	Verify the accuracy of all additions and updates to the provider master file within one (1) business day of entry.
Response:	
Require Modification?	
4.7.21	Make corrections to errors discovered during the provider verification process on the same business day as identified.
Response:	
Require Modification?	
4.7.22	Perform additions, updates, verification, and corrections to the provider master file within the same business day, when it is the last day prior to the claims processing cycle.
Response:	
Require Modification?	
4.7.23	Check periodically, as specified by the contracting organization, for any error occurrences of duplicate provider numbers. Report the findings along with the actions taken to resolve the duplicate situation to the contracting organization within five (5) business days.
Response:	
Require Modification?	
4.7.24	Notify the contracting organization of contract terminations and upcoming renewals, as appropriate.
Response:	
Require Modification?	
4.7.25	Allow providers the ability to maintain their own provider demographic information.

Response:	
Require Modification?	
4.7.26	Provide a portal to allow providers to pick up pre-authorizations, as determined by contracting organization agreements regarding the generation of pre-authorizations.
Response:	
Require Modification?	

Grievance and Appeals Process Management

4.8.1	Track grievances and complaints in an established tracking system through referral to the contracting organization, and following resolution direction from the contracting organization.
Response:	
Require Modification?	
4.8.2	Identify the type and priority of grievances and complaints (e.g. urgent, emergency, routine).
Response:	
Require Modification?	
4.8.3	Generate periodic reports as specified by the contracting organization including, but not limited to: - Case status. - Grievance. - Complaints. - Appeals counts and information.
Response:	
Require Modification?	

4.8.4	Process all formal grievances, complaints, and appeals (written and oral) according to the required schedule and contracting organization policy and guidelines. Responsibilities for processing all grievances, complaints and appeals include, but are not limited to: - Generation and distribution of confirmations acknowledging receipt of grievance or appeal. - Interaction with designated contracting organization staff regarding grievances, complaints and appeals. - Assurance that responses to requests for information and processing adhere to timelines specified by the contracting organization. - Attendance at, or participation in, complaint and appeal review meetings, as requested. - Documentation of all contacts regarding grievances and appeals including source, date, information requested, received, and sent.
Response:	
Require Modification?	
4.8.5	Begin processing grievances and complaints within one (1) business day of receipt.
Response:	
Require Modification?	
4.8.6	Provide a confirmation letter to the service provider confirming receipt of the grievance within five (5) business days of receipt.
Response:	
Require Modification?	
4.8.7	Accommodate separate grievance and appeal processes by program.
Response:	
Require Modification?	
4.8.8	Review and respond to recipient appeal letters as directed by the contracting organization.
Response:	

Require Modification?	

Customer Service and Support Functions

4.9.1	Provide a training plan that identifies activities leading up to, and including, the training of providers and user staff, at all levels, in the proper use of the system and functions performed under this contract. The plan should include a description of the training objectives, methods, schedule, and activities and include details on the feedback and evaluation mechanisms that will be used. Requirements also include: - Description of training materials. - Description of training facilities (e.g., use of screens). - Training schedule. - Plans for remedial training. - Methodology to ensure continued training for staff changing positions, and new service providers. - Ongoing evaluation using specified evaluations.
Response:	
Require Modification?	
4.9.2	Provide user training and technical assistance at start-up and periodically for new users that focuses on business processes, use of the system, and is tailored to the staff position or user role (e.g., clerical users, manager).
Response:	
Require Modification?	
4.9.3	Provide dedicated training and technical assistance to providers at start-up to facilitate transition, and to new providers as they are added to the provider network.
Response:	
Require Modification?	

4.9.4	Use training materials for training staff that are appropriate to that type of training and delivery method. All materials should meet the following requirements: - Facilitate updating. - Be written in a procedural, step-by-step format. - Have instructions for sequential functions follow the flow of actual activity. - Present error messages for all fields incurring edits and the necessary steps to correct the errors. - Contain illustrations of windows and screens with all data elements and fields identified.
Response:	
Require Modification?	
4.9.5	Develop and conduct a training evaluation process and submit a summary of the results of that evaluation to the contracting organization.
Response:	
Require Modification?	
4.9.6	Issue recipient mailings, as directed by the contracting organization.
Response:	
Require Modification?	
4.9.7	Provide training, as specified in training plans to users and service providers.
Response:	
Require Modification?	
4.9.8	Produce individual recipient explanation of benefits upon request.
Response:	
Require Modification?	

4.9.9	Assist contracting organization staff with research, resolution, and response to customer service calls and contacts.
Response:	
Require Modification?	
4.9.10	Notify the contracting organization of all legislative or executive level and media contacts.
Response:	
Require Modification?	
4.9.11	Provide access to a test system or testing resources to allow the contracting organization the ability to test changes to set up, access test results, conduct joint development of set-up test plans, and test changes made to contracting organization systems that feed TPA processes.
Response:	
Require Modification?	
4.9.12	Provide a single contract representative for each organization's contract with authority to make decisions and establish service levels. Identify primary and secondary backup contact resources for functional area supports (e.g., provider record set up, claims processing, accounts receivable).
Response:	
Require Modification?	
4.9.13	Provide resources with specialized skills to support contract specific set up and transition activities (e.g., provider record set up, history conversions).
Response:	
Require Modification?	
4.9.14	Produce and distribute recipient explanation of benefits in accordance with federal regulations to all, or a sample of, individual recipients using selection criteria defined by the contracting organization. Statements shall be clear and

	easy to read and in logical plain English or other languages, as directed by the contracting organization.
Response:	
Require Modification?	
4.9.15	Provide call center and help desk services to providers and recipients, or a recipient's authorized representative, regarding claims status as well as assistance for vendor-supplied software or the vendor system use.
Response:	
Require Modification?	
4.9.16	Provide a dedicated call center and help desk resource that is trained and knowledgeable in the program, the atypical provider needs, and the community based claims business to better respond to atypical provider inquiries.
Response:	
Require Modification?	
4.9.17	Maintain a call and contact management tracking system used to manage inquiries from recipients, providers, legislators, attorneys, potential providers, and other stakeholders.
Response:	
Require Modification?	

4.9.18	Track calls and contacts with basic identifying information. The information shall include at a minimum: - Time and date of call or contact. - Provider name and identification number. - Caller name. - Nature and details of the call or contact. - Type of inquiry (e.g., phone, written, face to face, internet, email). - Length of call (for a phone contact). - Caller's county. - Customer service correspondent name and identification number. - Response given by customer service correspondent and the format in which the response was given (e.g., written, telephone, e-mail). - Status of inquiry (e.g., closed, follow-up needed). - Capacity for free form text of at least five hundred (500) characters to describe problems and resolutions.
Response:	
Require Modification?	
4.9.19	Create extract files or reports that contain summary information on all calls and contacts received during a specified timeframe.
Response:	
Require Modification?	
4.9.20	Provide the ability to refer and track calls and contacts to other contracting organization staff for follow-up. When the call or contact is referred, in addition to the basic identifying information, the referral shall include: - Call or contact priority. - Referral date. - Resolution due date. - Actual resolution date. - Referral person. - Name and/or identification number of the person resolving the call or contact. - Description of the resolution.
Response:	

Require Modification?	
4.9.21	Establish and maintain inquiry routing and escalation procedures, as specified by contracting organization agreement.
Response:	
Require Modification?	
4.9.22	Implement and maintain provider and recipient services customer service lines with toll-free numbers.
Response:	
Require Modification?	
4.9.23	Maintain sufficient provider customer service phone lines and customer service correspondent staff so that: - At least ninety-five percent (95%) of all calls are answered within three (3) rings. - No more than five percent (5%) of all answered calls are on hold for more than one (1) minute. - Ninety-five percent (95%) of all phone calls do not encounter a busy condition. - Less than 5 percent of all phone calls are abandoned or dropped.
Response:	
Require Modification?	
4.9.24	The call and contact management system must be available ninety-nine percent (99%) of the time per day.
Response:	
Require Modification?	
4.9.25	Calls and contacts needing further research or follow-up must be responded to within two (2) business days of initial contact. The caller must be given a final response or inform the caller/contact that further research is needed.
Response:	
Require	

Modification?	
4.9.26	Research and respond to technical policy, procedure, and pricing questions from providers and recipients, or a recipient's authorized representative.
Response:	
Require Modification?	
4.9.27	Respond to provider inquiries on claims status and payment information including, but not limited to: - Adjudicated claims. - Paid amount. - Claim status. - Denial reason. - Requests for electronic claim status capability.
Response:	
Require Modification?	
4.9.28	Maintain call statistics including but not limited to: - Time and Date of call. - Identifying information on call. - Call category. - Inquiry description. - Response description. - Busy. - Dropped calls. - Call wait time. - Length of call.
Response:	
Require Modification?	

4.9.29	Generate, at a minimum, the following types of daily, weekly, and monthly reports: - Incoming calls and contacts answered. - After hours calls and contacts. - Cumulative calls and contacts answered. - Total calls abandoned. - Abandoned or lost rate percent. - Average wait time. - Average hold time in queue. - Call topic.
Response:	
Require Modification?	
4.9.30	Deliver cultural diversity training to call and contact management center correspondents.
Response:	
Require Modification?	

Data Maintenance and Data Integrity

4.10.1	The security of the claims processing system must minimally provide the following three types of controls to maintain data integrity. These controls shall be in place at all appropriate points of processing. - Preventive Controls: controls designed to prevent errors and unauthorized events from occurring. - Detective Controls: controls designed to identify errors and unauthorized transactions that have occurred in the system. - Corrective Controls: controls to ensure that the problems identified by the detective controls are corrected.
Response:	
Require Modification?	

4.10.2	Allow entry, storage of, and access to provider data. Effective begin and end dates for appropriate elements must be provided. Provider data includes but is not limited to: - Provider Number. - Provider Name. - Provider type, specialty, and/or taxonomy. - Status. - Multiple addresses including mailing address, payment address, multiple practice location and prior authorization notice or other notice addresses. Address format must conform to postal regulations and allow a zip plus 4 digit code. - County and locality information. - Phone number(s). - Contact person(s). - Multiple fax numbers. - Multiple e-mail addresses. - National Provider Identifier (NPI). - Drug Enforcement Agency (DEA) number. - Social Security Number (SSN). - Federal Employer Identification Number (FEIN). - License number. - Categories of services for which a provider is allowed to bill. - Approved transactions under the Trading Partner Agreement. - Provider billing, rendering, or non-billing provider number and/or NPI.
Response:	
Require Modification?	
4.10.3	Participate in annual data integrity audits, as required by the DHS. Participate in state and federal systems audits, as required.
Response:	
Require Modification?	
4.10.4	Identify providers with a unique provider number using the National Provider Identifier (NPI), or standards consistent with NPI, and HIPAA requirements. Unique identifier information should include, but is not limited to, all locations, provider types, specialties, authorizations, certifications, licensing for services, and all other appropriate information

	for that provider as a logical record linked to the unique provider number.
Response:	
Require Modification?	
4.10.5	Track provider and recipient enrollment for special programs and allow other indicators as needed to identify program participation.
Response:	
Require Modification?	
4.10.6	Edit and verify accuracy of all entered data for presence, format, validity and consistency with other data in the update transactions for all files that allow update transactions (e.g., prevent duplicate provider enrollment).
Response:	
Require Modification?	
4.10.7	Maintain an audit trail on all update transactions, for all files that can be updated.
Response:	
Require Modification?	
4.10.8	Generate reports on any occurrences of duplicate provider or recipient numbers.
Response:	
Require Modification?	
4.10.9	Select and purge records according to a schedule specified by the contracting organization.
Response:	
Require Modification?	

4.10.10	Ensure the master provider file, pre-authorization file and any other relevant data files have been updated prior to the claims processing cycle.
Response:	
Require Modification?	
4.10.11	Support and maintain internal quality assurance (QA) processes to detect and correct problems in all functional areas, and support and maintain internal quality improvement (QI) processes to detect and prevent quality issues from occurring; use contracting organization reports as input to these processes.
Response:	
Require Modification?	
4.10.12	Develop and maintain a quality assurance program that is: - Implemented across all system and operational responsibilities. - Meets industry standards and best practices (e.g., ISO, QMS, TQM).
Response:	
Require Modification?	
4.10.13	Provide the capability to link and/or merge all recipient's data.
Response:	
Require Modification?	
4.10.14	Provide a process for unlinking all eligibility and claims data associated with a recipient when it is discovered that a recipient's eligibility has been merged erroneously with another recipient, has been erroneously split out from the recipient, or the identification number has been erroneously assigned to another recipient.
Response:	
Require Modification?	

Reporting

4.11.1	Generate required reports as defined by the DHS including, but not limited to: - Incurred But Not Reported (IBNR). - Outstanding liability, including from claims and authorizations. - Obligations based on authorization data. - Quality of transactions received. - Authorization trend reports (e.g., recipient consumption, compliance by category of service, by case manager). - Reports to accommodate estate recovery (e.g., claims and receivables history for deceased recipients).
Response:	
Require Modification?	
4.11.2	Generate claims control reports by program including, but not limited to, the following: - Invalid transactions. - Daily control activity. - Adjustments entered. - Corrections not applied. - Daily batch errors. - Inventory and production reports. - Daily management summary. - Error analysis. - Error summary. - Aged inventory - location age. - Aged inventory - system age. - Returned and denied claims.
Response:	
Require Modification?	
4.11.3	Generate additional reports with claims entry statistics for assessing claims processing performance compliance, as specified by the contracting organization.
Response:	
Require	

Modification?	
4.11.4	Generate aging reports, as specified by the contracting organization, to provide the ability to monitor work in progress or unfinished work in all areas of TPA responsibility including, but not limited to: - Claims. - Service authorizations. - Receivables. - New recipient set up. - Provider additions and changes. - Grievances and appeals.
Response:	
Require Modification?	
4.11.5	Generate additional aging reports as specified by the contracting organization including, but not limited to: - ISPs. - Customer services inquiries.
Response:	
Require Modification?	
4.11.6	Generate claims exception reports, as specified by the contracting organization, including: - Outliers. - High dollars. - High units.
Response:	
Require Modification?	
4.11.7	Provide a performance dashboard, available to contracting organization staff, by line of business that includes, but is not limited to claims inventory, claims and customer service turn-around time, and quality statistics.
Response:	
Require	

Modification?	
4.11.8	Generate and submit recipient-specific data in an encounter data format specified by the DHS and according to any HIPAA deadlines, standards and requirements applicable to the contracting organization. The specifications and HIPAA deadlines, standards and requirements are identified in documents found on the DHS web site at: http://dhs.wisconsin.gov/ltcare/Encounter.
Response:	
Require Modification?	
4.11.9	Accommodate the mandated requirements for encounter data reconciliation specified in the encounter reporting implementation guide, as required by contracting organization agreements. Encounter data reconciliation specifications are identified in documents found on the DHS web site at: http://dhs.wisconsin.gov/ltcare/Encounter.
Response:	
Require Modification?	
4.11.10	Generate standard reports as defined by the contracting organization including, but not limited to: - Open prior authorizations at any point in time. - Active prior authorizations versus claims received and processed. - Paid, denied, and adjusted claims. - Claims trend and analysis reports (e.g., submission times vs. dates of service for run out; lag reports by category of service, provider type). - Data entry time lag. - Claims lag (from date received to date check is mailed).
Response:	
Require Modification?	
4.11.11	Ensure that the system has the capability to track, assess, estimate, and report on: - The effectiveness and savings of each edit and audit (including revisions and updates). - The impact of each edit and audit (including revisions and updates) on providers (e.g., by individual provider, provider type, service type, place of service, claim type, type of claim submission, recipient type) and their subsequent billing patterns.

Response:	
Require Modification?	
4.11.12	Provide a regularly scheduled transmission of claims data to the contracting organization that includes all information included in the encounter data submissions, as defined in individual agreements.
Response:	
Require Modification?	

ADDITIONAL REQUIREMENTS FOR FAMILY CARE PARTNERSHIP

Claims Processing

5.1.1	Contract with a nationally recognized drug updating service to update drug prices weekly.
Response:	
Require Modification?	
5.1.2	Maintain DRG files to use in pricing inpatient and outpatient hospital claims. Seven (7) years of data must be maintained. The DRG file will contain, at a minimum, elements such as: - DRG code. - English translation of code (DRG description). - Add date. - Begin date. - End date. - DRG weight (relative value). - Outlier Days (low and high days). - Audit trail. - Average length of stay.
Response:	
Require	

Modification?	

Eligibility and Enrollment Maintenance

5.2.1	Accept multiple enrollment and termination dates for Medicare integrated program members: - Medicare fee for service benefits are effective the first of the month in which eligibility is granted and terminate the end of the month, in which coverage is terminated. - Medicare managed care integrated benefits are effective on the first day of the first full month in which eligibility is granted and terminate on the last day of the month in which coverage is terminated. - Medicaid Partnership is effective on the day on which eligibility is granted and terminates on the day on which coverage is terminated.
Response:	
Require Modification?	
5.2.2	Maintain a benefit and pricing structure for both the Medicare and Medicaid Partnership components of the integrated plan.
Response:	
Require Modification?	
5.2.3	Calculate Partnership plan benefits in their entirety using an internal, integrated coordination of benefits process, without requiring the providers to resubmit claims and producing one final remittance advice reflecting the benefit calculations of both plans.
Response:	
Require Modification?	
5.2.4	Calculate the benefit, assuming that Medicare is the primary insurer and Partnership is the secondary insurer. In cases where other insurance exists, standard COB primacy rules would be followed for benefit calculations, in addition to the internal benefit calculations for the integrated Medicare/Partnership plan.
Response:	
Require	

Modification?	
5.2.5	Produce a single service record that reflects these calculations in claims history (and/or encounter transactions) which does not inflate units, services charges or other claims data.
Response:	
Require Modification?	
5.2.6	Process coordinated benefits based on multiple enrollment and termination dates: - Coordinate benefits using standard COB rules for the time period between the effective date of the Partnership benefit and the first of the month in which Medicare managed care integrated benefits become effective. - Coordinate benefits based on the internal COB requirements for the period of time from the first of the month in which Medicare integrated benefits become effective and the date that Medicaid Partnership benefits terminate.
Response:	
Require Modification?	
5.2.7	Process Medicare managed care benefits from the date Medicaid Partnership ends through the end of the month in which Medicare managed care benefits terminate.
Response:	
Require Modification?	
5.2.8	Process dental claims.
Response:	
Require Modification?	
5.2.9	Provide and maintain current and historical DRG numbers, narrative descriptions, rates, weights, and effective dates to be used in claims processing and that supports accurate DRG assignment.
Response:	
Require	

Modification?	
5.2.10	Recalculate payments resulting from post pay DRG validation reviews. The revised ICD coding used for DRG may be in either electronic or paper format. The appropriate DRG validation must be based on date of discharge.
Response:	
Require Modification?	
5.2.11	Provide for inpatient hospital pricing methodologies including but not limited to: - DRG grouping. - DRG with outlier if an outlier is applicable. - Per diem. - Days eligible. - Percentage of charge. - Other methods specified by contracting organization agreements.
Response:	
Require Modification?	
5.2.12	Apply all outpatient hospital pricing methodologies as well as the ability to bundle certain revenue codes into a flat rate per revenue code. Outpatient hospital pricing methodologies include but are not limited to: - Rate per visit. - Flat rate per revenue code. - Rate per revenue code, service and procedure code, or billed amount (whichever is less). - Procedure code, and diagnosis code. - Percentage of charge per revenue code.
Response:	
Require Modification?	
5.2.13	Conduct post pay DRG validation reviews.
Response:	
Require	

Modification?	

Grievance and Appeals Process Management

5.3.1	Accommodate independent grievance and appeals processes for Medicare and Medicaid, based on eligibility and/or the service identified in the grievance or appeal (e.g., the Medicare and Medicaid Partnership programs require different tracking and notifications, including remittance advice messages).
Response:	
Require Modification?	

Reporting

5.4.1	Produce risk adjustment data submissions for CMS, as directed by the MCO.
Response:	
Require Modification?	

Pharmacy Benefit Management

5.5.1	Maintain a minimum of twenty-four (24) months of online, real-time pharmacy claims history, including records of all claim payments, accounting, reporting, and drug rebate.
Response:	
Require Modification?	
5.5.2	Develop necessary interfaces to assure the availability of accurate information regarding member eligibility, drug pricing information, provider eligibility, other insurance resources, member benefit limitations, managed care enrollment status, and other data necessary to process pharmacy claims.
Response:	
Require Modification?	

5.5.3	Calculate payments applying various co-pay arrangements as defined or approved by the MCO.
Response:	
Require Modification?	
5.5.4	Maintain the claim history, provider, recipient files and control reports for the MCO, based on state or federal requirements as appropriate.
Response:	
Require Modification?	
5.5.5	Generate reports based upon selected pharmacy and physician criteria, such as: - NDCs, generic drug codes, or therapeutic classification codes of drugs and specific diagnosis codes. - NDCs, generic drug codes, or therapeutic classification codes and quantities of drugs prescribed by a specific physician or filled by a specific pharmacy.
Response:	
Require Modification?	
5.5.6	Perform or subscribe to services for the following operational PBM responsibilities including but not limited to: - Negotiating supplemental rebates. - Maintaining preferred drug list. - Reviewing and approving prior authorization requests and criteria. - Providing customer service. - Quality and patient safety. - Formulary management and development.
Response:	
Require Modification?	
5.5.7	Accept and process all retail pharmacy claims consistent with MCO policy.
Response:	

Require Modification?	
5.5.8	Provide the ability to adjudicate drug claims based on Medicare Part D requirements.
Response:	
Require Modification?	
5.5.9	Accept multiple National Drug Codes (NDCs) to support compound drug pricing.
Response:	
Require Modification?	
5.5.10	Apply different dispensing fees to drug claims based on MCO criteria.
Response:	
Require Modification?	
5.5.11	Track and provide reports to compare actual acquisition cost and usual and customary charge information to billed charges on drug claims.
Response:	
Require Modification?	
5.5.12	Perform POS editing of pharmacy claims to identify non-covered drugs based on a table of state approved Generic Code Numbers (GCN), and/or NDCs, or NDC ranges not covered by specified benefit plans; notify the provider through an online, real-time response when a drug is not covered.
Response:	
Require Modification?	
5.5.13	Provide POS edits for drugs requiring prior authorization.

Response:	
Require Modification?	
5.5.14	Edit POS claims for a valid prescriber number.
Response:	
Require Modification?	
5.5.15	Support POS managed care editing for inclusion or exclusion of pharmacy services.
Response:	
Require Modification?	
5.5.16	Price POS pharmacy claims consistent with state reimbursement rules in accordance to MCO policy including, but not limited to: - The ingredient Maximum Allowable Cost (MAC). - Estimated Acquisition Cost (EAC). - Average Wholesale Price (AWP). - Appropriate dispensing fees. - Pharmaceutical care. - Compound drugs.
Response:	
Require Modification?	

5.5.17	The processing requirements for Prospective DUR include identification and monitoring drug usage for FFS claims including but not limited to: - Over utilization. - Under utilization. - Therapeutic duplication. - Drug and/or disease contraindication. - Drug and/or drug interaction. - Incorrect drug dosage. - Incorrect duration of drug treatment.
Response:	
Require Modification?	
5.5.18	Generate the following Prospective DUR reports including but not limited to: - Summarization report of the severity and the number of alerts that have occurred over a given period. Based upon the results of this report, specific reports to display additional detail for any given type or category of alert may be requested by the State. Listings of all drug claims and diagnostic information per member and the amount of money involved. - User-defined period of time (e.g., all DUR activity that occurred for a date range). - Dispensing statistics for prescription filled from the preferred drug list. - Alerts and/or denials by types, quantity, and by prescribing provider and pharmaceutical provider.
Response:	
Require Modification?	
5.5.19	Validate DEA information prior to update. Automate the reconciliation of data accuracy between the DEA subscription information and the provider data. Automatically correct invalid information. Validate and report discrepancies periodically to the MCO, as specified by the MCO agreement.
Response:	
Require Modification?	
5.5.20	Provide expertise to negotiate best prices and rebates.

Response:	
Require Modification?	

ADDITIONAL REQUIREMENTS FOR CHILDREN'S AND OTHER WAIVERS

Claims Processing

6.1.1	Accept local service coding values on waiver claims for community-based non-medical services throughout a pre-defined transition period.
Response:	
Require Modification?	
6.1.2	Provide the flexibility to calculate, issue, and report claims payments or hold claims payments in accordance with individual county waiver agency agreements.
Response:	
Require Modification?	

Eligibility and Enrollment Maintenance

6.2.1	Accommodate user defined enrollment termination reasons by program.
Response:	
Require Modification?	
6.2.2	Accommodate the termination of benefits based on various age limitations or service maximums, over-riding pre-authorization data.
Response:	
Require	

Modification?	

Service Authorization Management

6.3.1	Capture specific information on waiver claims based upon pre-authorization service types.
Response:	
Require Modification?	
6.3.2	Provide the ability to over-ride authorizations for intensive services when they exceed the program limit, even when the services are pre-authorized.
Response:	
Require Modification?	

Reporting

6.4.1	Develop reports for intensive service costs by participant within specified date range (requires data collection regarding county of financial responsibility, begin and end dates of intensive service period, dates of service, and service codes for intensive services).
Response:	
Require Modification?	

APPENDIX B; COST PROPOSAL FORM

COST PROPOSAL FORM

Bidding / Proposing Company Name: _____

Address: _____

_____

Contact Name: _____

Contact Phone: _____

The attached cost proposal is submitted in response to Bid/Proposal # **1677-DLTC-PM**.

Cost Category	Amount
4.0 CORE BUSINESS SYSTEM COSTS FOR ALL CONTRACTING ORGANIZATIONS	
Bulletin Level Development (flat fee)	$
Bulletin Level Setup (flat fee)	$
Organization Level Contracting (per hour)	$
Please specific monthly claims volume range for each price. Add additional lines as needed for claims volume ranges.	
Per Member, Per Month (PMPM) claims volume _____	$
Per Member, Per Month (PMPM) claims volume _____	$
Per Member, Per Month (PMPM) claims volume _____	$
Optional Contracting Functions (flat fee)	$
5.0 ADDITIONAL BUSINESS SYSTEM COSTS FOR FAMILY CARE PARTNERSHIP	
Additional Per Member, Per Month (PMPM), if any.	$
6.0 ADDITIONAL BUSINESS SYSTEM COSTS FOR CHILDREN'S AND OTHER WAIVERS	
Additional Per Member, Per Month (PMPM), if any.	$

Identify any anticipated increases or discounts (e.g., volume pricing, pricing of electronic vs. paper volume).

Company Name _____

Authorized Representative* _____
Signature

Authorized Representative _____
Type or Print

Date _____

* A person authorized to commit the entity to a legal and binding contract must sign this form.

APPENDIX C; STANDARD TERMS AND CONDITIONS

Standard Terms And Conditions
(Request For Bids / Proposals)

1.0 SPECIFICATIONS: The specifications in this request are the minimum acceptable. When specific manufacturer and model numbers are used, they are to establish a design, type of construction, quality, functional capability and/or performance level desired. When alternates are bid / proposed, they must be identified by manufacturer, stock number, and such other information necessary to establish equivalency. The State of Wisconsin shall be the sole judge of equivalency. Bidders/proposers are cautioned to avoid bidding alternates to the specifications which may result in rejection of their bid/proposal.

2.0 DEVIATIONS AND EXCEPTIONS: Deviations and exceptions from original text, terms, conditions, or specifications shall be described fully, on the bidder's/proposer's letterhead, signed, and attached to the request. In the absence of such statement, the bid/proposal shall be accepted as in strict compliance with all terms, conditions, and specifications and the bidders/proposers shall be held liable.

3.0 QUALITY: Unless otherwise indicated in the request, all material shall be first quality. Items which are used, demonstrators, obsolete, seconds, or which have been discontinued are unacceptable without prior written approval by the State of Wisconsin.

4.0 QUANTITIES: The quantities shown on this request are based on estimated needs. The state reserves the right to increase or decrease quantities to meet actual needs.

5.0 DELIVERY: Deliveries shall be F.O.B. destination freight prepaid and included unless otherwise specified.

6.0 PRICING AND DISCOUNT: The State of Wisconsin qualifies for governmental discounts and its educational institutions also qualify for educational discounts. Unit prices shall reflect these discounts.

6.1 Unit prices shown on the bid/proposal or contract shall be the price per unit of sale (e.g., gal., cs., doz., ea.) as stated on the request or contract. For any given item, the quantity multiplied by the unit price shall establish the extended price, the unit price shall govern in the bid/proposal evaluation and contract administration.

6.2 Prices established in continuing agreements and term contracts may be lowered due to general market conditions, but prices shall not be subject to increase for ninety (90) calendar days from the date of award. Any increase proposed shall be submitted to the contracting agency thirty (30) calendar days before the proposed effective date of the price increase, and shall be limited to fully documented cost increases to the contractor which are demonstrated to be industry wide. The conditions under which price increases may be granted shall be expressed in bid/proposal documents and contracts or agreements.

6.3 In determination of award, discounts for early payment will only be considered when all other conditions are equal and when payment terms allow at least fifteen (15) days, providing the discount terms are deemed favorable. All payment terms must allow the option of net thirty (30).

7.0 UNFAIR SALES ACT: Prices quoted to the State of Wisconsin are not governed by the Unfair Sales Act.

8.0 ACCEPTANCE-REJECTION: The State of Wisconsin reserves the right to accept or reject any or all bids/proposals, to waive any technicality in any bid/proposal submitted, and to accept any part of a bid/proposal as deemed to be in the best interests of the State of Wisconsin.

Bids/proposals MUST be date and time stamped by the soliciting purchasing office on or before the date and time that the bid/proposal is due. Bids/proposals date and time stamped in another office will be rejected. Receipt of a bid/proposal by the mail system does not constitute receipt of a bid/proposal by the purchasing office.

9.0 METHOD OF AWARD: Award shall be made to the lowest responsible, responsive bidder unless otherwise specified.

10.0 ORDERING: Purchase orders or releases via purchasing cards shall be placed directly to the contractor by an authorized agency. No other purchase orders are authorized.

11.0 PAYMENT TERMS AND INVOICING: The State of Wisconsin normally will pay properly submitted vendor invoices within thirty (30) days of receipt providing goods and/or services have been delivered, installed (if required), and accepted as specified.

Invoices presented for payment must be submitted in accordance with instructions contained on the purchase order including reference to purchase order number and submittal to the correct address for processing.

A good faith dispute creates an exception to prompt payment.

12.0 TAXES: The State of Wisconsin and its agencies are exempt from payment of all federal tax and Wisconsin state and local taxes on its purchases except Wisconsin excise taxes as described below.

The State of Wisconsin, including all its agencies, is required to pay the Wisconsin excise or occupation tax on its purchase of beer, liquor, wine, cigarettes, tobacco products, motor vehicle fuel and general aviation fuel. However, it is exempt from payment of Wisconsin sales or use tax on its purchases. The State of Wisconsin may be subject to other states' taxes on its purchases in that state depending on the laws of that state. Contractors performing construction activities are required to pay state use tax on the cost of materials.

13.0 GUARANTEED DELIVERY: Failure of the contractor to adhere to delivery schedules as specified or to promptly replace rejected materials shall render the contractor liable for all costs in excess of the contract price when alternate procurement is necessary. Excess costs shall include the administrative costs.

14.0 ENTIRE AGREEMENT: These Standard Terms and Conditions shall apply to any contract or order awarded as a result of this request except where special requirements are stated elsewhere in the request; in such cases, the special requirements shall apply. Further, the written

contract and/or order with referenced parts and attachments shall constitute the entire agreement and no other terms and conditions in any document, acceptance, or acknowledgment shall be effective or binding unless expressly agreed to in writing by the contracting authority.

15.0 APPLICABLE LAW AND COMPLIANCE: This contract shall be governed under the laws of the State of Wisconsin. The contractor shall at all times comply with and observe all federal and state laws, local laws, ordinances, and regulations which are in effect during the period of this contract and which in any manner affect the work or its conduct. The State of Wisconsin reserves the right to cancel this contract if the contractor fails to follow the requirements of s. 77.66, Wis. Stats., and related statutes regarding certification for collection of sales and use tax. The State of Wisconsin also reserves the right to cancel this contract with any federally debarred contractor or a contractor that is presently identified on the list of parties excluded from federal procurement and non-procurement contracts.

16.0 ANTITRUST ASSIGNMENT: The contractor and the State of Wisconsin recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the State of Wisconsin (purchaser). Therefore, the contractor hereby assigns to the State of Wisconsin any and all claims for such overcharges as to goods, materials or services purchased in connection with this contract.

17.0 ASSIGNMENT: No right or duty in whole or in part of the contractor under this contract may be assigned or delegated without the prior written consent of the State of Wisconsin.

18.0 WORK CENTER CRITERIA: A work center must be certified under s. 16.752, Wis. Stats., and must ensure that when engaged in the production of materials, supplies or equipment or the performance of contractual services, not less than seventy-five percent (75%) of the total hours of direct labor are performed by severely handicapped individuals.

19.0 NONDISCRIMINATION / AFFIRMATIVE ACTION: In connection with the performance of work under this contract, the contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01(5), Wis. Stats., sexual orientation as defined in s. 111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the contractor further agrees to take affirmative action to ensure equal employment opportunities.

19.1 Contracts estimated to be over twenty-five thousand dollars ($25,000) require the submission of a written affirmative action plan by the contractor. An exemption occurs from this requirement if the contractor has a workforce of less than twenty-five (25) employees. Within fifteen (15) working days after the contract is awarded, the contractor must submit the plan to the contracting state agency for approval. Instructions on preparing the plan and technical assistance regarding this clause are available from the contracting state agency.

19.2 The contractor agrees to post in conspicuous places, available for employees and applicants for employment, a notice to be provided by the contracting state agency that sets forth the provisions of the State of Wisconsin's nondiscrimination law.

19.3 Failure to comply with the conditions of this clause may result in the contractor's becoming declared an "ineligible" contractor, termination of the contract, or withholding of payment.

20.0 PATENT INFRINGEMENT: The contractor selling to the State of Wisconsin the articles described herein guarantees the articles were manufactured or produced in accordance with applicable federal labor laws. Further, that the sale or use of the articles described herein will not infringe any United States patent. The contractor covenants that it will at its own expense defend every suit which shall be brought against the State of Wisconsin (provided that such contractor is promptly notified of such suit, and all papers therein are delivered to it) for any alleged infringement of any patent by reason of the sale or use of such articles, and agrees that it will pay all costs, damages, and profits recoverable in any such suit.

21.0 SAFETY REQUIREMENTS: All materials, equipment, and supplies provided to the State of Wisconsin must comply fully with all safety requirements as set forth by the Wisconsin Administrative Code and all applicable OSHA Standards.

22.0 WARRANTY: Unless otherwise specifically stated by the bidder/proposer, equipment purchased as a result of this request shall be warranted against defects by the bidder/proposer for one (1) year from date of receipt. The equipment manufacturer's standard warranty shall apply as a minimum and must be honored by the contractor.

23.0 INSURANCE RESPONSIBILITY: The contractor performing services for the State of Wisconsin shall:

23.1 Maintain worker's compensation insurance as required by Wisconsin Statutes, for all employees engaged in the work.

23.2 Maintain commercial liability, bodily injury and property damage insurance against any claim(s) which might occur in carrying out this agreement/contract. Minimum coverage shall be one million dollars ($1,000,000) liability for bodily injury and property damage including products liability and completed operations. Provide motor vehicle insurance for all owned, non-owned and hired vehicles that are used in carrying out this contract. Minimum coverage shall be one million dollars ($1,000,000) per occurrence combined single limit for automobile liability and property damage.

23.3 The state reserves the right to require higher or lower limits where warranted.

24.0 CANCELLATION: The State of Wisconsin reserves the right to cancel any contract in whole or in part without penalty due to nonappropriation of funds or for failure of the contractor to comply with terms, conditions, and specifications of this contract.

25.0 VENDOR TAX DELINQUENCY: Vendors who have a delinquent Wisconsin tax liability may have their payments offset by the State of Wisconsin.

26.0 PUBLIC RECORDS ACCESS: It is the intention of the state to maintain an open and public process in the solicitation, submission, review, and approval of procurement activities.

Bid/proposal openings are public unless otherwise specified. Records may not be available for public inspection prior to issuance of the notice of intent to award or the award of the contract.

27.0 PROPRIETARY INFORMATION: Any restrictions on the use of data contained within a request, must be clearly stated in the bid/proposal itself. Proprietary information submitted in response to a request will be handled in accordance with applicable State of Wisconsin procurement regulations and the Wisconsin public records law. Proprietary restrictions normally are not accepted. However, when accepted, it is the vendor's responsibility to defend the determination in the event of an appeal or litigation.

27.1 Data contained in a bid/proposal, all documentation provided therein, and innovations developed as a result of the contracted commodities or services cannot by copyrighted or patented. All data, documentation, and innovations become the property of the State of Wisconsin.

27.2 Any material submitted by the vendor in response to this request that the vendor considers confidential and proprietary information and which qualifies as a trade secret, as provided in s. 19.36(5), Wis. Stats., or material which can be kept confidential under the Wisconsin public records law, must be identified on a Designation of Confidential and Proprietary Information form (DOA-3027). Bidders/proposers may request the form if it is not part of the Request for Bid/Request for Proposal package. Bid/proposal prices cannot be held confidential.

28.0 DISCLOSURE: If a state public official (s. 19.42, Wis. Stats.), a member of a state public official's immediate family, or any organization in which a state public official or a member of the official's immediate family owns or controls a ten percent (10%) interest, is a party to this agreement, and if this agreement involves payment of more than three thousand dollars ($3,000) within a twelve (12) month period, this contract is voidable by the state unless appropriate disclosure is made according to s. 19.45(6), Wis. Stats., before signing the contract. Disclosure must be made to the State of Wisconsin Ethics Board, 44 East Mifflin Street, Suite 601, Madison, Wisconsin 53703 (Telephone 608-266-8123).

State classified and former employees and certain University of Wisconsin faculty/staff are subject to separate disclosure requirements, s. 16.417, Wis. Stats.

29.0 RECYCLED MATERIALS: The State of Wisconsin is required to purchase products incorporating recycled materials whenever technically and economically feasible. Bidders are encouraged to bid products with recycled content which meet specifications.

30.0 MATERIAL SAFETY DATA SHEET: If any item(s) on an order(s) resulting from this award(s) is a hazardous chemical, as defined under 29CFR 1910.1200, provide one (1) copy of a Material Safety Data Sheet for each item with the shipped container(s) and one (1) copy with the invoice(s).

31.0 PROMOTIONAL ADVERTISING / NEWS RELEASES: Reference to or use of the State of Wisconsin, any of its departments, agencies or other subunits, or any state official or employee for commercial promotion is prohibited. News releases pertaining to this procurement shall not be made without prior approval of the State of Wisconsin. Release of broadcast e-mails pertaining to this procurement shall not be made without prior written authorization of the contracting agency.

32.0 HOLD HARMLESS: The contractor will indemnify and save harmless the State of Wisconsin and all of its officers, agents and employees from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the operations of the contractor, or of any of its contractors, in prosecuting work under this agreement.

33.0 FOREIGN CORPORATION: A foreign corporation (any corporation other than a Wisconsin corporation) which becomes a party to this Agreement is required to conform to all the requirements of Chapter 180, Wis. Stats., relating to a foreign corporation and must possess a certificate of authority from the Wisconsin Department of Financial Institutions, unless the corporation is transacting business in interstate commerce or is otherwise exempt from the requirement of obtaining a certificate of authority. Any foreign corporation which desires to apply for a certificate of authority should contact the Department of Financial Institutions, Division of Corporation, P. O. Box 7846, Madison, WI 53707-7846; telephone (608) 261-7577.

34.0 WORK CENTER PROGRAM: The successful bidder/proposer shall agree to implement processes that allow the State agencies, including the University of Wisconsin System, to satisfy the State's obligation to purchase goods and services produced by work centers certified under the State Use Law, s.16.752, Wis. Stat. This shall result in requiring the successful bidder/proposer to include products provided by work centers in its catalog for State agencies and campuses or to block the sale of comparable items to State agencies and campuses.

35.0 FORCE MAJEURE: Neither party shall be in default by reason of any failure in performance of this Agreement in accordance with reasonable control and without fault or negligence on their part. Such causes may include, but are not restricted to, acts of nature or the public enemy, acts of the government in either its sovereign or contractual capacity, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes and unusually severe weather, but in every case the failure to perform such must be beyond the reasonable control and without the fault or negligence of the party.

APPENDIX D; SUPPLEMENTAL STANDARD TERMS AND CONDITIONS

Supplemental Standard Terms and Conditions for Procurements for Services

1.0 ACCEPTANCE OF BID/PROPOSAL CONTENT: The contents of the bid/proposal of the successful contractor will become contractual obligations if procurement action ensues.

2.0 CERTIFICATION OF INDEPENDENT PRICE DETERMINATION: By signing this bid/proposal, the bidder/proposer certifies, and in the case of a joint bid/proposal, each party thereto certifies as to its own organization, that in connection with this procurement:

2.1 The prices in this bid/proposal have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder/proposer or with any competitor;

2.2 Unless otherwise required by law, the prices which have been quoted in this bid/proposal have not been knowingly disclosed by the bidder/proposer and will not knowingly be disclosed by the bidder/proposer prior to opening in the case of an advertised procurement or prior to award in the case of a negotiated procurement, directly or indirectly to any other bidder/proposer or to any competitor; and

2.3 No attempt has been made or will be made by the bidder/proposer to induce any other person or firm to submit or not to submit a bid/proposal for the purpose of restricting competition.

2.4 Each person signing this bid/proposal certifies that: He/she is the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein and that he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above; (or)

He/she is not the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein, but that he/she has been authorized in writing to act as agent for the persons responsible for such decisions in certifying that such persons have not participated, and will not participate in any action contrary to 2.1 through 2.3 above, and as their agent does hereby so certify; and he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above.

3.0 DISCLOSURE OF INDEPENDENCE AND RELATIONSHIP:

3.1 Prior to award of any contract, a potential contractor shall certify in writing to the procuring agency that no relationship exists between the potential contractor and the procuring or contracting agency that interferes with fair competition or is a conflict of interest, and no relationship exists between the contractor and another person or organization that constitutes a conflict of interest with respect to a state contract. The Department of Administration may waive this provision, in writing, if those activities of the potential contractor will not be adverse to the interests of the state.

3.2 Contractors shall agree as part of the contract for services that during performance of the contract, the contractor will neither provide contractual services nor enter into any agreement to provide services to a person or organization that is regulated or funded by the contracting agency or has interests that are adverse to the contracting agency. The Department of Administration may waive this provision, in writing, if those activities of the contractor will not be adverse to the interests of the state.

4.0 DUAL EMPLOYMENT: Section 16.417, Wis. Stats., prohibits an individual who is a State of Wisconsin employee or who is retained as a contractor full-time by a State of Wisconsin agency from being retained as a contractor by the same or another State of Wisconsin agency where the individual receives more than $12,000 as compensation for the individual's services during the same year. This prohibition does not apply to individuals who have full-time appointments for less than twelve (12) months during any period of time that is not included in the appointment. It does not include corporations or partnerships.

5.0 EMPLOYMENT: The contractor will not engage the services of any person or persons now employed by the State of Wisconsin, including any department, commission or board thereof, to provide services relating to this agreement without the written consent of the employing agency of such person or persons and of the contracting agency.

6.0 CONFLICT OF INTEREST: Private and non-profit corporations are bound by ss. 180.0831, 180.1911(1), and 181.0831 Wis. Stats., regarding conflicts of interests by directors in the conduct of state contracts.

7.0 RECORDKEEPING AND RECORD RETENTION: The contractor shall establish and maintain adequate records of all expenditures incurred under the contract. All records must be kept in accordance with generally accepted accounting procedures. All procedures must be in accordance with federal, state and local ordinances.

The contracting agency shall have the right to audit, review, examine, copy, and transcribe any pertinent records or documents relating to any contract resulting from this bid/proposal held by the contractor. The contractor will retain all documents applicable to the contract for a period of not less than three (3) years after final payment is made.

8.0 INDEPENDENT CAPACITY OF CONTRACTOR: The parties hereto agree that the contractor, its officers, agents, and employees, in the performance of this agreement shall act in the capacity of an independent contractor and not as an officer, employee, or agent of the state. The contractor agrees to take such steps as may be necessary to ensure that each subcontractor of the contractor will be deemed to be an independent contractor and will not be considered or permitted to be an agent, servant, joint venturer, or partner of the state.

APPENDIX E; DESIGNATION OF CONFIDENTIAL AND PROPRIETARY INFORMATION

STATE OF WISCONSIN
DOA-3027 N(R01/98)

DESIGNATION OF CONFIDENTIAL AND PROPRIETARY INFORMATION

The attached material submitted in response to Bid/Proposal # **1677-DLTC-PM** includes proprietary and confidential information which qualifies as a trade secret, as provided in s. 19.36(5), Wis. Stats., or is otherwise material that can be kept confidential under the Wisconsin Open Records Law. As such, we ask that certain pages, as indicated below, of this bid/proposal response be treated as confidential material and not be released without our written approval.

Prices always become public information when bids/proposals are opened, and therefore cannot be kept confidential.

Other information cannot be kept confidential unless it is a trade secret. Trade secret is defined in s. 134.90(1)(c), Wis. Stats. as follows: "Trade secret" means information, including a formula, pattern, compilation, program, device, method, technique or process to which all of the following apply:

1. The information derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use.
2. The information is the subject of efforts to maintain its secrecy that are reasonable under the circumstances.

We request that the following pages not be released:

Section	Page #	Topic

IN THE EVENT THE DESIGNATION OF CONFIDENTIALITY OF THIS INFORMATION IS CHALLENGED, THE UNDERSIGNED HEREBY AGREES TO PROVIDE LEGAL COUNSEL OR OTHER NECESSARY ASSISTANCE TO DEFEND THE DESIGNATION OF CONFIDENTIALITY AND AGREES TO HOLD THE STATE HARMLESS FOR ANY COSTS OR DAMAGES ARISING OUT OF THE STATE'S AGREEING TO WITHHOLD THE MATERIALS.

Failure to include this form in the bid/proposal response may mean that all information provided as part of the bid/proposal response will be open to examination and copying. The state considers other markings of confidential in the bid/proposal document to be insufficient. The undersigned agrees to hold the state harmless for any damages arising out of the release of any materials unless they are specifically identified above.

Company Name _____

Authorized Representative _____
Signature

Authorized Representative _____
Type or Print

Date _____

This document can be made available in accessible formats to qualified individuals with disabilities.

APPENDIX F; VENDOR INFORMATION FORM

STATE OF WISCONSIN
DOA-3477 (R05/98)

Bid / Proposal #**1677-DLTC-PM** _____

Commodity / Service _____

VENDOR INFORMATION

1 BIDDING / PROPOSING COMPANY NAME _____

FEIN _____

Phone ( ) _____ Toll Free Phone ( ) _____

FAX ( ) _____ E-Mail Address _____

Address _____

City _____ State _____ Zip + 4 _____

2 Name the person to contact for questions concerning this bid / proposal.

Name _____ Title _____

Phone ( ) _____ Toll Free Phone ( ) _____

FAX ( ) _____ E-Mail Address _____

Address _____

City _____ State _____ Zip + 4

3 Any vendor awarded over $25,000 on this contract must submit affirmative action information to the department. Please name the Personnel / Human Resource and Development or other person responsible for affirmative action in the company to contact about this plan.

Name _____ Title _____

Phone ( ) _____ Toll Free Phone ( ) _____

FAX ( ) _____ E-Mail Address _____

Address _____

City _____ State _____ Zip + 4

4 Mailing address to which state purchase orders are mailed and person the department may contact concerning orders and billings.

Name _____ Title _____

Phone ( ) _____ Toll Free Phone ( ) _____

FAX ( ) _____ E-Mail Address _____

Address _____

City _____ State _____ Zip + 4

5 CEO / President Name _____

This document can be made available in accessible formats to qualified individuals with disabilities.

APPENDIX G; VENDOR REFERENCE FORM

STATE OF WISCONSIN
DOA-3478 (R12/96)

Bid / Proposal #**1677-DLTC-PM**

VENDOR REFERENCE

FOR VENDOR: _____

Provide company name, address, contact person, telephone number, and appropriate information on the product(s) and/or service(s) used for four (4) or more installations with requirements similar to those included in this solicitation document. If vendor is proposing any arrangement involving a third party, the named references should also be involved in a similar arrangement.

Company Name

Address (include Zip + 4) _____

Contact Person _____ Phone No. _____

Product(s) and/or Service(s) Used _____

_____

_____

Company Name _____

Address (include Zip + 4) _____

Contact Person _____ Phone No. _____

Product(s) and/or Service(s) Used _____

_____

_____

Company Name _____

Address (include Zip + 4) _____

Contact Person _____ Phone No _____

Product(s) and/or Service(s) Used _____

_____

_____

Company Name _____

Address (include Zip + 4) _____

Contact Person _____ Phone No. _____

Product(s) and/or Service(s) Used _____

_____

_____

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